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SMALL BUSINESS ACCESS TO HEALTH CARE

HEARING

BEFORE THE

COMMITTEE ON SMALL BUSINESS
HOUSE OF REPRESENTATIVES

ONE HUNDRED SEVENTH CONGRESS

SECOND SESSION

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HEARING ON SMALL BUSINESS ACCESS TO HEALTH CARE

WEDNESDAY, FEBRUARY 6, 2002

HOUSE OF REPRESENTATIVES,
COMMITTEE ON SMALL BUSINESS,
Washington, DC.

The Committee met, pursuant to call, at 10:05 a.m. in room 2360, Rayburn House Office Building, Hon. Donald Manzullo, (chairman of the committee) presiding.

Chairman MANZULLO. Good morning. We will call our Small Business meeting to order. Before any opening statements or anything, I want to move immediately to the testimony of Dr. Fletcher, who has three other Subcommittee hearings he has to attend.

Congressman Dr. Fletcher, we look forward to your testimony. You are up.

[Chairman Manzullo's statement may be found in the appendix.]

STATEMENT OF HON. ERNIE FLETCHER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF KENTUCKY

Mr. FLETCHER. Thank you very much, Mr. Chairman. I want to thank the Chairman and the Ranking Member for providing me this opportunity to testify regarding the Small Business Health Fairness Act, which I filed back last May.

Let me note that there are about 12 Members on this Committee that are co-sponsors of that bill, including the Chairman and the Ranking Member. Also, 18 Committee Members voted for the AHP amendment to the Patients' Bill of Rights. As you know, this amendment passed the House and is included in the final House version. I want to thank you all for your support.

America's growing health care dilemma calls for immediate presidential and congressional action. We must address the fact that too many Americans lack health insurance. Experts estimate that at least 38 million Americans are currently without health insurance.

Additionally, the recession and terrorist acts of September 11 have increased the ranks of the uninsured by an estimate of one million people. The uninsured include some of the most vulnerable in our society—12 million children, 17 million low income Americans, seven million African-Americans, and 11 million Hispanics.

Those without health coverage confront barriers that discourage preventive care and delay disease diagnosis. They are more likely to be hospitalized for avoidable conditions. In fact, last year nearly 40 percent of the uninsured adults skipped recommended medical tests and treatments, and 20 percent did not get needed care for serious problems. Consequently, studies reveal that morbidity and

mortality rates among the uninsured are substantially higher than those among individuals with health insurance.

As double digit health premium increases and a weakened economy put more and more small business workers in jeopardy of losing their health benefits, we must turn our attention to the problem of the uninsured this year. I would like to stress that I believe we need to do it early this year.

In light of the ongoing discussions between the President and the Senate regarding the Patients' Bill of Rights, it is critical that the final bill take action on comprehensive small business health insurance reform. I feel strongly that this should include enactment of the Small Business Health Fairness Act of 2001, bipartisan legislation approved by the House as an amendment to the Patients' Bill of Rights.

I fear that the number of uninsured Americans will increase dramatically over the next few years if we do not act now. The Small Business Health Fairness Act would address this problem by creating new association health plans or AHPs for workers employed in small business, as well as the self-employed. This bill will provide working families employed by small businesses, which make up 60 percent of the uninsured, with more health benefits and more health plan choices.

Lacking the bargaining power of large corporations, many of these businesses are priced out of the health insurance marketplace, reluctantly leaving their workers uncovered. AHPs address this problem by allowing small businesses to band together nationally into associations to provide health insurance at lower cost.

Small businesses and the self-employed do not have the same advantages in the marketplace as the corporations and the larger union health plans. In fact, small employers now pay 18 percent more for coverage than large employers. Moreover, corporate and union health plans operating under one set of rules across state lines are able to take advantage of the economies of scale.

As you may know, the three main arguments against AHP are, one, adverse selection or what is called cherry picking; two, inadequate solvency standards; and, three, inadequate oversight enforcement. Let me address these myths regarding AHPs.

First, it is illegal for AHPs to deny coverage based on health status of any individual employer or employee under HIPAA. Cherry picking is possible only when sick or high risk people who will generate significant claims can be denied coverage. Of course, that does not happen under the way the AHP legislation is constructed. It is forbidden.

Secondly, the bill contains strict requirements under which only bona fide professional and trade associations, which exist for substantial purposes other than providing health insurance must exist for at least three years, can sponsor at AHP. The bill strictly prohibits health plans that are set up only to offer health insurance or accept only good risks.

Thirdly, to the extent that low and high risk industries can be identified, the bill only allows new self-funded AHPs in industries with average or above average risk profiles, thus preventing self-funded AHPs from forming in low risk industries.

Fourthly, opponents' allegations about adverse selection rest on the mistaken assumption that small businesses will only offer bare bones benefit packages through AHPs. However, small business owners and workers desire the same benefit packages as large business workers, and small businesses must offer comparable benefit options to attract and retain employees.

Fifthly, adverse selection that currently exists in state markets will be greatly reduced when younger, healthier workers employed in small businesses who are now uninsured are able to obtain coverage that is affordable.

This Act contains tough, new solvency provisions which will actually increase consumer protections for many small business workers. The DOL's IG has testified before Congress that the new enforcement tools for regulators contained in this legislation will help reduce health insurance fraud.

The bill gives federal and state authorities new and better enforcement tools to insure that coverage is secure and to prevent health insurance fraud. Only longstanding, bona fide associations meet the bill's strict eligibility requirements and are independent of insurance companies. Tough, new solvency standards require claims reserves certified by a qualified actuary, minimum surplus reserves, both specific and aggregate stop loss insurance and indemnification insurance to insure that all claims are paid.

A.H.P.s must register with the state in which they are domiciled. AHPs must abide by strict disclosure and actual reporting procedures, and the bill provides new criminal and civil penalties. Allegations that health coverage obtained through AHPs will be anything less than secure ignore these strong protections contained.

A.H.P.s are fundamentally different, too, from MEWAs. Multiple employer welfare plans generally will not qualify as AHPs under the new certification process. AHPs will be regulated in a manner similar to how single employer and labor union pension and health plans are currently regulated. Thus, the bill does not require an entire new bureaucracy to insure that AHPs are properly regulated.

The DOL already regulates association sponsored health plans for compliance with current federal laws governing group health plans. This bill strengthens solvency standards and certification rules to plans operated by qualifying bona fide trade and professional associations.

D.O.L. is devoted to identifying, investigating and disbanding fraudulent MEWAs. This is the case for many state insurance departments as well. Since the bill provides new enforcement capabilities that will assist DOL and state insurance departments in identifying and shutting down fraudulent MEWAs and preventing new ones from getting started, resources can be redirected to the regulation of bona fide AHPs under new standards in the law. The bill provides that associations applying for certification as federally regulated AHPs must pay a $5,000 filing fee. This will generate resources to enhance enforcement.

The bill allows the Secretary to consult with the states in regulating AHPs and provides that new self-insured AHPs be subject to the assessment of state premium taxes and equivalent assessments, thus providing resources that can be used for regulatory responsibility.

D.O.L. also has enhanced criminal and civil enforcement powers currently not available to stop health insurance fraud by terminating bogus small employer and union health plans. Illegitimate entities will become criminal enterprises, and DOL will have a new cease and desist authority to curtail such activities. The DOL IG has stated that these are important and necessary in stopping health insurance fraud.

It is only fair that we should level——

Chairman MANZULLO. Dr. Fletcher, I know your time is limited. I have you at eight minutes, but I want to leave some time for you and for some Members to ask you some questions.

Mr. FLETCHER. Let me just conclude that I think it is very important to level the playing field, and I think it is critical that we pass this legislation this year.

I appreciate the opportunity to testify.

[Mr. Fletcher's statement may be found in the appendix.]

Chairman MANZULLO. Okay. I appreciate that. I have a couple of questions for the doctor. Does anybody else have any questions for Dr. Fletcher on his bill?

Mr. PASCRELL. Yes.

Chairman MANZULLO. Mr. Pascrell.

I am sorry. Ms. Velázquez, did you have any questions you wanted to ask of Dr. Fletcher?

Ms. VELÁZQUEZ. Sure.

Chairman MANZULLO. Why don't you go ahead?

Ms. VELÁZQUEZ. I just would like to know if we could get the Speaker to bring this legislation to the Floor?

Mr. FLETCHER. You know, we already have passed the legislation, but certainly I will be glad to work with you and any other Members to see if we can bring actually the Small Business Health Fairness Act to the Floor as an individual bill.

Ms. VELÁZQUEZ. Thank you.

Chairman MANZULLO. Mr. Pascrell.

Mr. PASCRELL. Thank you. Congressman, what would you say to the major criticism, since we seem to be moving towards some resolution on this hopefully? What would you say to the major criticism from the larger insurance companies? What is their major problem, in your eyes, about this?

Mr. FLETCHER. I think first they were considering and many were looking at MEWAs and the problems. There was a failed MEWA in California and some other association plans there.

We have strengthened several things that they had concerns about. First was if a patient has a problem, who picks up the phone when they call and ask? We certainly coordinated with the Commissioners of Insurance in the states that they can answer the phone. We provided funds to them to enhance enforcement so that there are some consumer protections. We also increased the requirements and reserves. The actual reporting actually on a quarterly basis is required.

I think the insurance companies had very legitimate concerns about making sure that the individuals were protected. We also required stop loss insurance, which we did not previously, so I think we have answered most of their criticisms.

Mr. PASCRELL. Thank you.

Chairman MANZULLO. Mrs. Kelly.

Mrs. KELLY. Thank you. I want to say that I strongly applaud your stand, Dr. Fletcher, on AHPs, and I strongly support your bill. I believe I am a co-sponsor of that bill. I think it is extremely important that we allow the AHPs to come into existence.

In the past, since my father was a doctor, I have seen what has happened over the course of many years through the medical system. I have been involved in it myself. I think that we must, because I am also a small businesswoman. I think it is extremely important that we meet the challenge of insuring people and allowing more people to access insurance by doing the AHPs.

I just simply want to make the statement that I applaud you for your stand, and I support you.

Mr. FLETCHER. Thank you, Congresswoman Kelly.

Chairman MANZULLO. Congresswoman Tubbs Jones, did you have any questions you wanted to ask of our colleague?

Mrs. JONES. No, I do not. Thank you.

Chairman MANZULLO. Okay. Dr. Fletcher, let me ask a real basic question that goes to the real definition of insurance. Why is it that large groups of people that want to form together, want to band together, in order to buy insurance are unable to do so other than the obvious answer of affordability?

Mr. FLETCHER. Well, there are several things. Let me take the State of Kentucky as an example where we had a small individual market.

What happened when there were certain regulations is without guaranteed issue we had a spiraling increase in cost of health care because without being able to bring large groups of people together which have different risk, you are not able to take advantage of economies of scale, of spreading the risk, and that is what insurance is about.

Additionally, what the good union plans and large corporation plans do is that they have one set of administration rules across the 50 states, which improves efficiency tremendously. What we want to do is allow small businesses, so I think it certainly gets right to the heart of insurance, especially the protections that we put in, the reserves and the stop loss insurance.

Let me say in response to Congresswoman Kelly's statement there that the largest growing segment of small businesses is women initiated businesses. This gives them the advantage of certainly being able to offer their employees I think a quality health insurance product at a cost that is substantially lower than what they may be able to get otherwise.

Chairman MANZULLO. You used the term spreading the risk. That is the definition of insurance, is it not? You form a large pool where you have a lot of healthy people and then some sick people, and everybody contributes an equal amount. The purpose is to spread the risk so that when there is a need for insurance that the money that is pooled will be used for the people that obviously have the need.

Mr. FLETCHER. You are right, Mr. Chairman, and the more efficiently you can run the insurance product, the lower you can keep the premium, and the more attractive it is to healthy individuals. The higher the premiums go out, we find the healthy individuals

drop out because it is a risk/benefit or cost/benefit analysis that, you know, each individual goes through when they are looking at purchasing insurance.

Chairman MANZULLO. One of the arguments that is used against AHPs is the fact that it cherry picks, that you can form groups only of healthy people. I mean, how can the National Restaurant Association have more healthy people than the NFIB or any other trade association? I do not know how we come up with that standard.

But, Dr. Fletcher, is essentially what you are trying to do is offer small business people the same type of insurance benefits that members of unions have, because unions have been out in front of this issue for 50 years by allowing the insurance to follow the individual, as opposed to the individual having to get his insurance through the employer?

Mr. FLETCHER. Mr. Chairman, absolutely. As a matter of fact, some of the union plans are some of the best plans and the best coverage across the country, so I laud them for the work that they have done. We just want to offer the same opportunity for small businesses to provide that sort of plan with that sort of efficiency.

As we look at this, it really is an issue of leveling the playing field and making sure that everyone can provide the best health care benefits possible.

Chairman MANZULLO. I know years ago when my father, who was a union carpenter, transitioned from being a full-time carpenter into the full-time restaurant business he struggled to make sure he kept his union card and kept his union insurance benefits because even years ago it was much cheaper and there was much better coverage through his local than there would have been if he had been at purchasing insurance independently for the small restaurant business that he founded years ago.

Mr. FLETCHER. You are absolutely right. The provisions that I outline in the bill really prohibit cherry picking. An association has to have existed for three years. They have to be associated for a purpose other than offering health insurance.

Chairman MANZULLO. So you cannot form an organization just for the purpose of having an AHP?

Mr. FLETCHER. You are absolutely right. If you form a new association even for other purposes and have a below average risk—in other words, if you try to form an association that would include only healthy people—it is prohibited by the bill.

Chairman MANZULLO. So you cannot form an association and as a basis of the association you have to pass some kind of a medical examination?

Mr. FLETCHER. Absolutely.

Chairman MANZULLO. Okay. I have no further questions. How are you doing on time, Dr. Fletcher?

Mr. FLETCHER. I think, you know, I will be glad to take as much time as you need.

Chairman MANZULLO. Does anybody else have any questions of Dr. Fletcher?

[No response.]

Chairman MANZULLO. If not, thank you for coming. I appreciate it very much.

Mr. FLETCHER. Mr. Chairman, Ranking Member and Members of the Committee, thank you for this privilege.

Chairman MANZULLO. Thank you.

Before we go down the order, Congressman Tubbs Jones, you have a constituent you would like to introduce even though it may not be that person's time to testify right now.

Mrs. JONES. Thank you, Mr. Chairman. Thank you, Mr. Chairman, and other Members of the Committee. It is my pleasure [TECHNICAL DIFFICULTIES]. His name is Mr. Raymond Arth of Phoenix Products, Inc. Mr. Arth's company manufactures faucets for manufactured housing and RVs. He came here today to discuss the health plan he participates in offered by GWI, a wholly owned subsidiary of the Growth Association.

In Cleveland, the Growth Association is our chamber of commerce. It is probably one of the largest chambers of commerce in the country, and they operate a program. They have a small business organization called COSE, Council of Small Enterprises, that offers health care insurance to employees of that business.

I thank you, Mr. Arth, for coming to our Committee this morning, and I am pleased to introduce you to my colleagues and Members of the Committee and people in the audience. Thanks very much, sir, for coming.

Mr. ARTH. Thank you very much.

Chairman MANZULLO. Okay. Ms. Velazquez, do you have an opening statement?

Ms. VELÁZQUEZ. Thank you, Mr. Chairman. I appreciate your initiative in calling this hearing on such an important subject.

We have a health care crisis in this country. Today, 40 million Americans, or one in seven, almost 15 percent, do not have health coverage. The number has dropped in the past couple of years. It is still unacceptably high, and I fear the slowing economy will swell the ranks of the uninsured again.

The great majority of Americans get health coverage through their employer. There is a reason for this. Companies, especially large ones, can get the best deal to contain cost. It is not surprising then that only 42 percent of companies with fewer than 100 employees provide health coverage for their workers, while 95 percent of companies with more than 100 employees provide health coverage.

In fact, 60 percent of uninsured people, 24 million Americans, live in families where the head of the household works for a small business. Self-employed people account for ten million uninsured Americans, including two million children.

Most small business owners would like to provide health coverage for their employees and their families, but they are restricted by cost. This is the main reason why health care coverage was named as one of the top 11 small business issues for this Congress in a report the Democrats released last month.

These companies want to provide health coverage for their employees, but cannot. This is not a one size fits all proposition. No one solution would cover the entire diversity of small businesses. Nonetheless, we have two strong proposals that can help these companies help their workers.

First, we can accelerate the 100 percent deductibility of health care premiums. We are now at 70 percent, with the full 100 percent coming nearly two years later from now. There is no reason why we should not make that 100 percent available right now. I hope we can work together to put this powerful incentive into effect immediately.

Another proposal is the association health plan which would allow small businesses and the self-employed to band together in industry specific groups and leverage their collective strength to provide better and more affordable health care options than they would alone. AHPs could level the playing field, putting small business purchasing and bargaining power on par with their corporate counterparts. It would be a hedge against precipitous price hikes that make it difficult for small businesses to continue offering health benefits when they have them.

A.H.P.s and 100 percent deductibility are just two very good possibilities. Still, there are other options to learn about. That is the purpose of this hearing.

But I think we should keep one ultimate goal in mind while we listen to our witnesses and various new policy proposals. Our goal must be to continue expanding the number of American working families with health care coverage. It is the right thing to do, for our country and our future.

Thank you very much.

[Ms. Velázquez's statement may be found in the appendix.]

Chairman MANZULLO. Thank you.

Let us move on to our first witness, which is Elaine P. Smith, president of E. Smith & Associates of Granite City, Illinois.

Where is Granite City?

Ms. SMITH. Southern Illinois.

Chairman MANZULLO. Is that between your district and mine? Okay. Well, you are at the bottom of the state, and I am at the top of the state, so she has to be in between. Right.

We look forward to your testimony. We have a five minute clock.

Ms. SMITH. Okay.

Chairman MANZULLO. Green is okay. When it gets to yellow, that means you have a minute. When it gets to red, then we need you to conclude.

We look forward to your testimony.

STATEMENT OF ELAINE P. SMITH, PRESIDENT, E. SMITH & ASSOCIATES

Ms. SMITH. Good morning, Mr. Chairman and Members of the Committee. Thank you for inviting me here from Illinois to talk about important issues of affordable, accessible health insurance, especially for those of us who own or work for small businesses. I am pleased to be here on behalf of the National Federation of Independent Business representing 600,000 members who face a similar challenge.

My name is Elaine Smith, and I own E. Smith & Associates, which is a promotional marketing and fulfillment company based in Granite City, Illinois, just across the river, the Mississippi River, from downtown St. Louis.

At E. Smith & Associates, my employees and I work together to develop, market and sell point of sale displays, corporate merchandise and other related advertising support materials for companies such as Anheuser-Busch, Ralston-Purina, Energizer Battery, Snapple and Motorola, to name a few. For Ralston-Purina, my company has fulfilled over four million How to Raise a Healthy Puppy and Kitten kits that are marketed to veterinarians and veterinary schools.

E. Smith & Associates was born out of an opportunity to become an outside vendor for various Anheuser-Busch projects. At the time I was employed by Anheuser-Busch, but in 1986 I left the corporate world to work out of my basement with just one employee. Since then, E. Smith has grown to 12 full-time employees and approximately 80 temporary workers that occupy three warehouse facilities and over 100,000 square feet. My employees range in skill level from high school graduates to college graduates and in age from teens to mid-fifties and earn an average salary of $25,000 to $35,000.

Like many entrepreneurs, I learned early that I could not compete with the large corporations in the area of extensive benefit packages. Instead, when hiring employees I offered perks that big companies could not—flexible and individualized schedules, the chance to move up the skill ladder quickly and so on.

For many years I did not offer health insurance as a benefit. In fact, having come out of the corporate world, I truly had not given much thought to health insurance at all. It was a standard in the work arena from which I had come, and I had never stopped to think about who was paying for the benefit and how much it really cost. However, in recent years two experiences forced me to stop and think about health insurance and what role an employer should play.

First, I began to realize that my small business attitude and start up perks were not enough to attract and retain talented, highly educated workers. At E. Smith, I run a formal college internship program providing marketing experience to students from Ball State University, Southern Illinois University and all the local junior colleges. Ideally, I like to hire these interns after they graduate. However, former interns began to turn my employment offers down because of the lure of benefit packages offered by larger corporations. I quickly realized I needed to increase the types of benefits I offered, namely health insurance.

The second experience was more personal than business. A good employee who had been with me for quite some time experienced a series of common ailments—sinus, sore throats, cough, flu. She just could not seem to get well.

Chairman MANZULLO. Elaine, excuse me. If you could get right into the meat of the plan that you offer?

Ms. SMITH. Yes.

Chairman MANZULLO. The same with the other witnesses. You have a great background, but I do not want you to run out of time.

Ms. SMITH. You got it.

Chairman MANZULLO. Okay.

Ms. SMITH. Last year, I decided to provide employer sponsored health coverage. I knew I wanted to provide a quality plan—med-

ical, dental and vision—with a great network of doctors, and I knew I needed to set parameters in order to afford it. I set an eligibility requirement of one year and a 50/50 employer/employee contribution rate.

In searching for a plan to meet these objectives, I was quite surprised to learn how difficult it was to find an affordable plan. However, I proceeded and began offering the benefit to our employees, to four of them. Eight others were covered by spouses or parents. Employees paid $125 a month, with employees with dependents covered paying an average of $250 a month. My idea was to manage the first year's benefit while developing plans to extend the benefit the following year so that as the employees' seniority increased so would the premium contribution paid by our company.

Everything seemed to be going smoothly. We budgeted accordingly so more employees could be added to our plan at our annual renewal. Therefore, I was completely flabbergasted when I received my first annual policy renewal statement with a whopping 26 percent increase for apparently no particular reason. Naturally I contacted my insurance representative to inquire about the big jump in cost. I was told quite simply that double digit increases were not atypical for small business owners and, in his words, were just the nature of the health care market.

My first reaction was to replace the current plan with something more affordable. However, after preliminary research I realized that in order to keep the quality of my plan my choices were very limited. Knowing that providing health insurance is necessary for both business and personal reasons and knowing that I cannot increase prices to my customers an extra 26 percent in order to absorb the cost, I reluctantly renewed the policy.

Ironically, a few months before receiving the health insurance premium increase I had taken another big step offering long-term and other insurances. All employees signed up to participate, and it reaffirmed my belief that insurance benefits are important. Therefore, I want to do my best to continue offering benefits, but if I face a 26 percent increase every year it will become more and more difficult or impossible.

A recent bipartisan poll asked 1,000 Americans what worries them most about the economy. The top response overwhelmingly was the rising health care cost, with one in three people listing it as their top concern.

Those in the small business community who are insured are struggling each year to afford the cost of increasing premiums. It is for this reason I support legislation endorsed by the NFIB that would create association health plans. AHPs will allow small business owners like myself to band together across state lines to purchase health insurance as part of a large group, thus insuring greater bargaining power, lower administrative cost and freedom from costly state insurance mandates.

Chairman MANZULLO. I am going to have to put a period right there on your testimony.

Ms. SMITH. Okay.

Chairman MANZULLO. Perhaps during the questioning we can get out the rest of it.

[Ms. Smith's statement may be found in the appendix.]

Chairman MANZULLO. Let me just mention to the rest. Please try to abide by the clock. Go right to the meat of your testimony, the stuff you really want us to hear.

If there is other stuff that you do not consider to be as important, throw that in at the end because we have a lot of Members with a lot of questions.

Elaine, thank you for participating.

Let me introduce to you Scott Shalek, who is my constituent. Scott, do you want to wave back there?

Scott is from McHenry County. He has been involved in the sale of insurance products for years. He was in town for a meeting with the trade association. I asked him to stay over so that he could listen to the testimony and give me some input later on.

Our next witness is Raymond Arth. Mr. Arth is the president of Phoenix Products in Avon Lake, Ohio. Mr. Arth?

STATEMENT OF RAYMOND ARTH, PRESIDENT, PHOENIX PRODUCTS, INC.

Mr. ARTH. Good morning, Mr. Chairman, Members of the Committee.

Chairman MANZULLO. If you could put the mike in front of you? Thank you.

Mr. ARTH. Yes. Thank you. Good morning, and thank you for the opportunity to be here today.

Adding to the Members' kind introduction, I would like to tell you that COSE runs a health plan for small businesses in greater Cleveland with 14,000 companies, 87,000 subscribers and nearly 200,000 covered lives. We also run chamber programs elsewhere in the State of Ohio.

I am also here today on behalf of National Small Business United, the country's oldest small business advocacy organization headquartered here in Washington. Health insurance has been one of our primary concerns for years.

After a period of relative stability, we are seeing costs escalating again. In our renewal last year, our most popular health care plan went up by 24 percent. Most of my employees elected to switch to another plan option, but we still were facing a 12 percent increase in premiums last year, and we expect much higher increases this year.

We believe there are some fundamental problems that need to be addressed, and probably chief among them is the fact that our health care delivery system runs on other people's money. If you are covered under Medicare or Medicaid, it is taxpayer funded. If you have private insurance, it is probably under an employer sponsored plan with your employer paying most or all of the cost. None of us spend other people's money as prudently as we spend our own.

We have a problem with cost shifting; that Medicare and Medicaid do not really pay all the costs for the services that are delivered. Those costs do not just disappear. They get shifted to the insured segment. Unfortunately, most of the burden will fall on small businesses that need to buy private insurance. Large self-insured groups do have the clout to avoid much of that burden.

We also have issues with state mandates that affect small business in particular. You have heard before about the ERISA preemption. We will not bother to revisit that.

If those are the problems, the question becomes what are some of the solutions we can deal with? COSE and NSBU, I believe, both were proponents of the MSA program when it was first discussed and enacted some years ago. The problem is it was not done correctly. We put caps on the number of plans that could be sold totally. We capped participation to companies fewer than 50 employees. My company with 60 employees is not eligible to offer an MSA.

With those caps, it was not attractive to insurance companies or banks to develop the products because there was no assurance there would be a big enough market to earn a return. The fact that I cannot offer it excludes a number of companies and insurers from the program.

The laws regulating HMOs prohibit the kind of cost shifting or cost sharing rather that would be required under an MSA program. About 40 percent of the people in this country are covered under an HMO program and hence would be ineligible to participate in an MSA. That would need attention here.

The rules are very complex. It is hard to develop and manage a plan. I may have to rely on my glasses here. Excuse me. There are also issues that the employer and the employee cannot make contributions into the savings components. If the employer makes a contribution, the employee may not.

We do have the Section 125 cafeteria plan also as a tool with respect to health care, but it is really only available to C corporations. If you are an LLC, a partnership, a sole proprietor, you cannot contribute to a Section 125 plan.

The Section 125 plan, with its use it or lose it provision, discourages some people from participating in the beginning and also encourages a lot of discretionary but perhaps unnecessary year-end spending to buy a new pair of glasses or other health services that would not otherwise be purchased rather than lose the dollar savings. Try to make a doctor's appointment in the month of December.

Another issue we need to address is the whole issue of tort reform. The cost of lawsuits is driving up the cost of health insurance. There is defensive medicine. There is the basic cost of malpractice insurance and so forth. We are very much in favor of holding providers responsible for incompetence or malpractice. We are very concerned about the provisions in the Patients' Bill of Rights especially as it relates to employer liability.

The Patients' Bill of Rights is expected to add 4.2 percent, which would translate into almost a million additional uninsured. If you add liability, quite frankly, I am not going to expose myself or my company to yet another range of reasons for my employees to sue me, and I would feel no choice but to get out of the health insurance business altogether. I would urge, in your considerations with respect to the Patients' Bill of Rights, that you be very sensitive to that potential problem.

At that point I guess I would be willing to wrap up my comments and yield back the balance of my time to keep things moving.

[Mr. Arth's statement may be found in the appendix.]

Chairman MANZULLO. You know the term of art, do you not? Yield back the balance of your time. I appreciate that. Thank you.

Our next witness is Robert Hughes. He is the president of the National Association for the Self-Employed. I look forward to your testimony.

STATEMENT OF ROBERT HUGHES, PRESIDENT, NATIONAL ASSOCIATION FOR THE SELF-EMPLOYED

Mr. HUGHES. Thank you, Mr. Chairman and Members of the Small Business Committee. I would like to thank you for this opportunity.

Chairman MANZULLO. Mr. Hughes, could you move the mike a little bit closer to your mouth? Thank you.

Mr. HUGHES. I would like to thank you for the opportunity to testify before you today to discuss small business health care issues. I am Robert Hughes, a self-employed CPA. I am also currently president of the National Association for the Self-Employed, a bipartisan, non-profit small business trade association that has over 200,000 members nationwide. Ninety percent of our membership consists of small businesses with five or fewer employees.

There are approximately 24 million small businesses in our nation. They account for 99 percent of America's employers and employ 53 percent of the private work force. Of the 43 million uninsured, approximately 24 million have family head that is self-employed or working in a firm with fewer than 100 employees.

According to the General Accounting Office's October, 2001, report on private health insurance, only 36 percent of employers with fewer than ten workers offered health coverage to their employees. The report cited the primary reason small employers gave for not offering coverage was cost.

These statistics are telling us that Congress and the Administration must focus on affordable health care in order to effectively reduce the number of uninsured in our nation. We strongly believe that association health plans and health care tax incentives, including tax deductions and tax credits for the self-employed, are necessary to provide affordable health coverage.

There are approximately 135,000 associations in existence today within the United States, and nearly every industry, profession, cause and interest is represented. Many associations also offer tangible value to their members through member benefits because of their group purchasing power and economies of scale.

Associations can also tailor benefits specifically to their membership's needs. Small businesses with five employees or under have very different needs from small businesses with 25, 100 or 250 employees. The self-employed and small business community should be able to pool their purchasing power in the acquisition of affordable health coverage, and association health plans, we believe, are a mechanism to do that.

On average, a worker in a firm with less than ten employees pays 18 percent more for health care than a worker in a firm with 200 or more employees. AHPs, we believe, can reduce health care costs by 15 to 30 percent by allowing small businesses to join together to obtain the same economies of scale, purchasing clout and

administrative efficiencies now available to employees in large employer and union health plans.

New coverage options for the self-employed and small business workers will promote greater competition and choice in health insurance markets. Tough new solvency standards protect patients' rights and insure benefits are paid.

Employee enticement and retention within the small business community are also a direct positive effect of association health plans. We believe AHPs would enhance the ability of the self-employed to obtain affordable health insurance coverage.

Tax credits and deductions are also a viable solution to achieve affordable health insurance. Existing inequities within the Internal Revenue Code should be addressed first to create parody between employer provided health insurance and health insurance for the self-employed with regard to social security and Medicare taxes.

Currently, premiums for employers and employees are not subject to FICA withholding tax, which is social security and Medicare. Thus, they enjoy health insurance premiums free from income tax and FICA tax.

However, health insurance premiums for the self-employed individuals are subject to self-employment tax for themselves and their dependents. The result is that the self-employed pay a premium on health insurance of up to 15.3 percent of the cost of that insurance. Combined with other non-deductible premiums, the self-employed pay an additional 25 percent for their health insurance.

By allowing the self-employed to claim their health care premiums as a business expense, the net cost of health insurance premiums will be reduced by up to 25 percent, which is a significant reduction in purchasing health insurance.

We believe further that a tax incentive, such as a refundable tax credit, should be made available for those who purchase health insurance coverage for up to $500 for individuals and $1,000 for families. A refundable tax credit should be made available to those individuals whose employer does not sponsor or contribute to an individual or family health plan for their employees and the unemployed. Self-employed individuals would have the opportunity to utilize either the self-employed health insurance deduction or the refundable tax credit, but not both.

We talk about numbers and statistics and plans here, but we want you to know that all of these items have individuals and faces to them throughout the country. We received a call this week from one of our members who indicated that his monthly premiums are going from $522 a month to $945 a month for his coverage. These double digit increases are going to be stifling for the self-employed and we believe will hurt the overall economy and the self-employed business nationwide.

Thank you, Mr. Chairman.

[Mr. Hughes' statement may be found in the appendix.]

Chairman MANZULLO. Thank you, Mr. Hughes.

Our next witness is Rick Curtis, president of the Institute for Health Policy Solutions here in Washington. I look forward to your testimony, Mr. Curtis.

STATEMENT OF RICK CURTIS, PRESIDENT, INSTITUTE FOR HEALTH POLICY SOLUTIONS

Mr. CURTIS. Thank you, Mr. Chairman. Just by background, we are a not-for-profit, independent institute. We largely focus on the working uninsured.

Chairman MANZULLO. Would you push that mike a little bit closer?

Mr. CURTIS. Okay. I am sorry. We work with private businesses. We work with consumer groups. We work with the government on approaches to coordinate with private employer coverage, and we have also worked on the development of what we call consumer choice purchasing groups in the private sector.

There are several of them that are thriving out there. There is one in Connecticut, the Connecticut Business and Industry Association. There is one in California under the umbrella of the Pacific Business Group on Health. There is one in Colorado some of you are aware of. There is a new one in New York City.

The interesting thing to note is that in the face of premium increases and the downturn in the economy you are all painfully aware of, their enrollment is going up substantially right now, which I think points to the obvious advantages of worker choice of competing health plans, which these kinds of organizations are structured to achieve.

I would note we do not take positions on things. We are not a trade association. I would note that most of these kinds of organizations are not a professional or trade association that would qualify as a bona fide association under the bill. They tend to be under the auspices of business groups on health that were formed by big employers to address quality issues and so forth, and then they have developed a purchasing pool. For small employers, organizations like COSE, of course, and like the Connecticut Business and Industry Association would qualify.

What I want to focus on, though, is this issue of the uninsured. In good times or bad, as you all know, a very large proportion of working uninsured are concentrated in small firms. While that is true, it is also important to note that there are more workers covered through their small firm than there are uninsured, and indeed there are more of them covered as a dependent through a spouse's employer than there are covered through individual coverage, so it makes sense as Congress thinks about the various proposals to extend coverage to the uninsured to do things that complements rather than replaces coverage through small firms.

As you all are well aware, surveys show that working Americans prefer coverage through their place of employment. Nevertheless, there are lots that do not have a stable place of employment, who are not full-time, full-year workers, whose small firm may not be viable yet. For them, you need other approaches.

The emerging details of the Administration's proposals here I think will give latitude for a lot of creative responses in both the private sector and the public sector, but our impression is there is this iron curtain in these proposals between the individual tax credit and the exemptions for employer based coverage, and we think that could be very unfortunate for an important sector of small employers, and those are the small employers who have a

majority of low wage workers. Some of them do offer coverage, a minority, but depending on how you define it, somewhere between 20, 30, 40 percent.

For those kinds of employers, I think it is very clear that the tax credits are going to be worth a lot more than the existing exemptions, so the advantages of employment based coverage will be lost. As has been mentioned in previous testimony, those advantages include retention of workers, as well as the convenience for the workers of payroll deductions and so forth.

While I am not privy to the details as they emerge, it looks as if there is this kind if iron curtain as there was in previous proposals, and we think there could be a fairly simple variation on the theme. There could be a sensible way to better reach the uninsured workers and dependents who do have this kind of employer who does want to somehow participate.

That would simply be this. That kind of an employer, and it would be defined, you know, fairly simply. The federal government through FICA forms and so forth knows the wage profile of small employers, and you would simply say those with a majority, for example, or two-thirds or 40 percent, whatever you wanted, whose workers make less than—pick your number—$20,000 a year would have an option of having their employees benefit from the tax credit instead of existing exemptions.

If the employer was willing to contribute something, that would be exempt from FICA taxation, not individual withholding, and then that employer could participate in these various kinds of pools that the Administration is proposing be available for tax credit recipients, but through the workplace.

We think that that kind of variation on the theme would be constructive for small employers and for the public purpose of reaching the working uninsured. You said to keep it brief. I will keep it brief.

[Mr. Curtis' statement may be found in the appendix.]

Chairman MANZULLO. I appreciate that. Thank you for your testimony.

Our next witness is Janet Trautwein, who is with the National Association of Health Underwriters. We look forward to your testimony.

STATEMENT OF JANET TRAUTWEIN, NATIONAL ASSOCIATION OF HEALTH UNDERWRITERS

Ms. TRAUTWEIN. Thank you. As we have heard earlier today, the current estimate on the number of uninsured in this country is approximately 40 million. Over half of the 40 million uninsured Americans are the working poor or near poor, and many of these people actually do have access already to health insurance through an employer plan. Unfortunately, although they have coverage available, many of them just cannot pay their share of the cost.

I know we are focusing today on ways to provide new access to small employers, but in doing so we need to keep in mind that whether it is from a group health plan, an association plan, some type of pooled arrangement, that health insurance premium is still calculated based on claims paid out. That is where you get a premium.

Many of the costly services that health insurance premiums are based on are not directly impacted by mandates, such as the cost of new technology, the cost of prescription drugs. Many of those are not affected at all by an exemption on mandates.

One of the reasons health insurance premiums are so high, as we have heard reported today, is that low income employees, many of whom are actually in relatively good health, cannot afford to participate in the employer's plan. This leaves the sicker employees as the ones that are participating and, as we discussed earlier, fewer participants over which to spread the risk of the entire group.

If we really want to lower the cost of health insurance, which is I think what we are talking about here today, regardless of what the insurance vehicle is we have to get greater participation in the plans that the employers offer. Even with financial contributions from employers, many low income people who must pay part of the cost of their plan still cannot afford their plan. Many of these employees work for small businesses.

While increased deductibility of health plan premiums for the self-employed has helped and will certainly help more as deductibility is increased, it does not do anything for the bulk of the uninsured who are the working poor with no or very low tax liability.

People with no tax liability do not benefit from a deduction for two reasons. First, if they owe no taxes there is nothing from which to deduct their premiums even if the deduction is available without the requirement that they itemize. Second, more important for the working poor, a deduction or a credit that is only available at the end of the year is of no value to them because they need the funds at the time the premiums are due. They cannot wait a year to be reimbursed, so they forego insurance entirely. That is why they are uninsured.

Fortunately, we think there is a solution to this problem and that it will address at least the participation problem of the uninsured, and that is a refundable, advanceable tax credit that would allow individuals to receive their tax credit dollars monthly when their premiums are due.

We also think it would help small employers who currently cannot afford to provide a health plan for their employees to offer a plan to the workers with the knowledge that employees had tax credit dollars to help pay the cost. Now, some tax credit proposals do not allow individuals to use a tax credit to pay their share of employer premiums. We think a better solution is to have a flexible tax credit that can be used either to help employees pay their share of their employer's plan or to buy coverage in the individual market if their employer does not offer a plan.

I would like to add one point of clarification here. There are a number of proposals out there that call for a tax credit to go to employers. There is nothing wrong with a tax credit to employers. We should do anything we can do incentivize employers to offer coverage.

However, let us keep in mind again today the number of employers that do already offer plans. Some of their very biggest challenges are in getting their low income employees to participate. If we only give the credit to the employers, that does not help those employees who are uninsured to pay their share of the cost, and

overall those health insurance premiums rates are not going to go down. We have to look at some sort of combination approach to make this work.

In conclusion, we think a refundable health insurance tax credit represents a simple and realistic way to extend private health insurance coverage to uninsured individuals and families who are most in need of assistance. It is an important component of an overall program to increase health care access for small business owners, and we think it would provide a real solution to the problem of the uninsured by addressing affordability, the most basic component of access to health care. It is a private sector solution to a difficult public problem, and it gives people the tools to make their own decisions.

We believe the most important patient protection is the ability to afford health insurance coverage and that real access to health care and choice cannot exist without the dollars to buy a health plan.

I appreciate this opportunity, and it looks like I have some time left, so thank you.

[Ms. Trautwein's statement may be found in the appendix.]

Chairman MANZULLO. Thank you for your testimony. All the written statements of the witnesses will be made part of the record.

Our next witness is Mary Nell is it Lehnhard?

Ms. LEHNHARD. Lehnhard.

Chairman MANZULLO. Mary Nell Lehnhard, who is with us. She is senior vice-president for policy at Blue Cross/Blue Shield, and we look forward to your testimony.

STATEMENT OF MARY NELL LEHNHARD, SENIOR VICE-PRESIDENT FOR POLICY, BLUE CROSS/BLUE SHIELD

Ms. LEHNHARD. Thank you, Mr. Chairman, Members of the Committee. Blue Cross and Blue Shield plans are committed to making small group coverage as stable and an affordable as possible. We offer coverage everywhere in the United States. We do no red lining. It is available to every small group.

Blue Cross and Blue Shield plans bring two messages to you today. First, we believe the problem of the uninsured should be addressed primarily by targeting small employers. The statistics speak for themselves. Two-thirds of the workers in small firms, groups under ten, are uninsured. We think the best way to address this is tax credits for low income workers in small firms. Often the employees have access to coverage, but they just cannot afford to pay their share of the premium, which is typically 50 percent.

Our second message is that exempting AHPs from state regulation will not meet the objectives of the proponents, but will result in very serious problems for small employers. Proponents argue primarily that AHPs are needed to create very large pools of small employees so you can negotiate with providers. States figured out that large pools were a good idea in the 1990s. Every state enacted a law, a pooling law, that said to every insurance company you put all of your small groups in one pool.

For Blue Cross and Blue Shield in a small state, this means tens of thousands of employees in one pool. In large states it means hundreds of thousands of employees of small employers in one pool.

This gives us maximum spreading of risk among major insurance companies in a state.

States have also said we have to limit how much we charge a sick group compared to a healthy group. The states have said we want maximum spreading of risk, and by law we are going to limit how much you can vary your premiums based on how sick a group is. I emphasize states have maximized the architecture of pooling and cross subsidies.

I would also note that the small employers get the same discount from providers that our large employers get. When we negotiate with a hospital in town, our small employers get that same rate as the largest company in town.

In fact, what we are concerned about is that AHPs will raise the cost for our small employer pools by making it very attractive for healthier groups to leave the pools, whether it is us or another insurance company, and join an AHP where there are no mandated benefits, and they do not need those benefits. The people who need the benefits would stay with the state insured pools and make the costs go up for those sicker small groups.

Proponents also argue that AHPs will reduce the number of uninsured, and I know the number the NFIB has put on is eight million. Only two independent studies have been done on this. CBO said they would reduce the number of uninsured by only about 300,000, but the premiums, because of the phenomena I just described, would go up for 80 percent of employers in the rest of the market. One reason their numbers are so high is because they used, for example, the entire Medicare population and made assumptions that they would join AHPs. We urge you to look at their assumptions.

The Urban Institute said there would be no increase in the uninsured because of AHPs, and, in fact, the number of uninsured would go up by one percent because of again risk selection against state insured pools raising the risk for sicker groups.

Not only would exempting AHPs from state regulation and oversight not achieve the objective. We think it will mean a return to the days of unregulated MEWAs, which were nothing but associations of employers exempt from state regulation and subject to regulation by the federal government. They were made subject to state regulation after very lengthy Senate hearings conducted by Senator Nunn citing how employer dollars were misused, misspent, sometimes fraudulently, sometimes because they did not have the expertise and they did not understand they were running an insurance company.

I would note that insurance regulation of insurance companies is intense. They review financial information quarterly, daily. If there is a problem, they move in with us. They co-sign checks above $500. If there is a problem, they review all our benefit structures to protect consumers. They review every one of our marketing materials so consumers are not misled. You cannot market a policy with ten days of coverage as comprehensive coverage.

They review our rates for small groups. They respond to consumer complaints and watch for signals that there might be a problem. For example, if providers are not paid the Insurance Commis-

sioner gets complaints and knows somebody might be running out of money.

Very importantly, and we can give you stories and evidence of this, they act very quickly to seize the assets of a company when they see the company going under because they are sitting in the company, so those assets cannot either go out of state or move offshore, and then there is no money left to pay providers, and the employers have to pay their employees' bills or the employees have to pay them.

D.O.L. will not have the authority or the resources to do these kinds of things to protect employers. AHPs will simply file a certificate certified by an actuary that they hire to DOL, and they are in business. They self-report to DOL when they run into trouble.

I would close by saying we have tried AHPs. Their economy was an association of employers. They did not work for consumers. It was a very public and heartbreaking series of hearings that the Senate went through, and we urge Congress not to reinvent them.

[Ms. Lehnhard's statement may be found in the appendix.]

Chairman MANZULLO. Thank you.

Our last witness is Duane Musser, technical consultant with the National Federation of Independent Businesses.

If you could pass the mike down to Mr. Musser?

Mr. MUSSER. Sir, I was not asked to give a statement. I was just asked to appear with the NFIB witness with respect to——

Chairman MANZULLO. For any technical questions?

Mr. MUSSER. For technical questions. If you would like me to say something, I will, but——

Chairman MANZULLO. No. That would be fine. I appreciate that. I appreciate that you are here.

I have a question here that I would like to ask Ms. Lehnhard. What is the solution? I had two ladies in the office yesterday. They both have Blue Cross/Blue Shield. One had 40 employees. One had eight employees. Their increase in premiums ranged between 35 and 47 percent for one year.

As they have been checking, they said the small employers are saying Blue Cross/Blue Shield is not interested in representing small employers. Tough question, but that is what they posed to me yesterday. They were from the National Association of Women Business Owners.

Ms. LEHNHARD. That is an excellent question. That is the heart of our business. We are local. That is our bread and butter. We are part of the community. That is our most important part of our business.

The reason health care premiums are going up is because hospital costs are going up 16 percent in the last 12 months, drug costs are going up 18 percent in the last 12 months, Medicare is not paying its fair share, so you put that on top of the 16 percent.

Chairman MANZULLO. But how much of an increase do you give to the large corporations that have the larger plans with you?

Ms. LEHNHARD. You look at the large employers. They are saying the same thing. Hospital costs are going up 16 percent. They are having the same experience.

Chairman MANZULLO. No. I am talking about your premiums to the large corporations that have the big pools. They are not going up anywhere near 35 to 47 percent.

Ms. LEHNHARD. No. They are. I think if you look at the data, large employers are experiencing very large increases.

Chairman MANZULLO. But not to that extent. I mean, the data shows conclusively that small employers pay 18 percent more in premiums than the average, than large employers.

Ms. LEHNHARD. I think if you look at that data, it included broker fees for small employers, which run about eight percent. It also included royalty paid by small firms to insurance companies.

These are assumptions for how AHPs would function, but they are costs that they assume that you have in a small group market that we do not have.

Chairman MANZULLO. So you are testifying that Blue Cross/Blue Shield charges the same premiums to a small employer as it does to a large employer?

Ms. LEHNHARD. No. I am saying that we are facing in all segments of our market the fact that hospital costs are going up 16 percent.

Chairman MANZULLO. I understand that, but are you saying that the rate of increase in premiums is the same to the small employer as to the large employer?

Ms. LEHNHARD. No. It will not be the same because of problems in the turnover in the small group market, which AHPs would experience, the fact that individuals in the small group market tend to be sicker because often they are——

Chairman MANZULLO. Because their pool is smaller.

Ms. LEHNHARD. No. Our pools for small employers are huge. It is all of our small group enrollment is in one pool in every state.

Chairman MANZULLO. Yes, but they are not rated according to that one pool.

Ms. LEHNHARD. Yes, they are. That pool is used to develop their premium. It can be adjusted based on age, sex, and in some states they let you adjust for health status, but it has a corridor on it like 25 percent or more.

Chairman MANZULLO. Do you mean the amount of increase cannot exceed 25 percent?

Ms. LEHNHARD. The amount of difference between your sickest and your healthiest group.

Chairman MANZULLO. Does anybody disagree with this? I mean, the data I have seen, the people I have talked to, the corporations I have talked to, their rate of increase is a lot less than the small businesses. I mean, that is why we are having the hearing.

Ms. LEHNHARD. I am not saying the rate of increase is the same. I am saying that large employees are experiencing double digit increases, and they are very alarmed about it.

Chairman MANZULLO. Then if the rate of increase with the large employers is not the same as for the small employers, is the reason for that that the small employers do not have enough people in their pool——

Ms. LEHNHARD. No.

Chairman MANZULLO [continuing]. In order to spread the risk?

Ms. LEHNHARD. No. You could not——

Chairman MANZULLO. What is the reason then?

Ms. LEHNHARD. Again, you have the maximum number of people in the pools right now because the states have said we have seven insurance companies in our state. All right. Blue Cross used to have 25 pools. You have one pool now for small groups. Aetna, you have to have one pool for small groups. Every insurance company can only have one pool, and they have to spread the risk across that entire pool.

Chairman MANZULLO. My brother and his wife run a restaurant. They pay—just the two of them; their kids are grown—$700 a month in premiums with a $5,000 deductible. Are they automatically in some kind of a pool in Illinois, two people?

Ms. LEHNHARD. They are probably in the Illinois small group pool. Now, you can have association health plans that are rated separately in some states. I do not know what Illinois law is. Rick Curtis follows all of this stuff closely.

Chairman MANZULLO. Please, could you explain that? Thank you.

Mr. CURTIS. Well, that may be an overstatement, but there are a couple differences here I think worth noting. One is different states do have different rating rules. Illinois is one that allows very substantial latitude in how a small employer is rated. Health status of the employees of a given group can have a big effect on rating.

Chairman MANZULLO. So if you have a small group where somebody has an illness, then the price goes through the roof for those premiums?

Mr. CURTIS. Yes. There are rate of increase limits usually. Even in a state like Illinois, they are there even though there is latitude.

Very often the example you gave before of a couple of women business owners who had 40 some percent, very often what is going on is they have a change in their employee composition. They get a new older employee or younger employee.

Chairman MANZULLO. No, they did not. What they did was they were told this by their insurance company, and the insurance company said well, it is because you have somebody here who is at risk. They said who is that risk? You know, what is going on here? They said well, we cannot tell you because of privacy issues.

They sat down and had a meeting with the owner of the business and the employees and said look, the insurance company wants to raise your rates by 45 to 47 percent. That means that we may have to cut back on your wages in order to put money into it.

They interviewed each of the people. Come to find out, it was one person in the group had a child with AHD. Is that what it is? The attention deficient disorder. ADD. Thank you. With ADD that saw a doctor once a year.

Then they turned back to the insurance company and said well, we have talked to everybody. The one child sees a doctor once a year. The insurance agent said well, yes, that is the person that the insurance company says is at risk, and that is why your premiums are going up 47 percent.

Ms. LEHNHARD. Mr. Chairman, I would just note as an aside that——

Chairman MANZULLO. I am getting a letter from her, and I am going to send it to her insurance company. I want in writing exactly what happened there.

Ms. LEHNHARD. That may be able to happen, but I would just note that will still be able to happen under AHPs. There is nothing that says everybody in the AHP pays the same rate.

Chairman MANZULLO. I accept that the rate of increase would be less because the pool is bigger.

Ms. LEHNHARD. No. The pool would not necessarily—the chamber of commerce in a state would not have maybe a bigger pool than a Blue Cross and Blue Shield plan. They can still vary the rate between groups.

Chairman MANZULLO. Mr. Curtis.

Mr. CURTIS. Yes. I was just going to say the groups I was talking about that offer consumers a choice do not allow those kinds of variations. They only allow age rating, but they only operate in states with pretty tight rating rules because if they did that, just as if an AHP did that, in a state that allows the sort of thing you are talking about they would be creamed to death. In the case of these kinds of groups, they would not have any plans to participate. You know, there is a reality of what happens in the outside market.

The other thing is the states that do have loose rating rules usually have a 15 percent rate of increase limit on how much a given employer's costs can go up in addition to what is called trend, and so if the trend is 15 percent and then you can add 15 percent on top of that and then you have an old worker come in or something, you are pretty soon up to 45 or 50 percent.

The state rating rules have a lot to do with what can happen to an individual small employer, but I would submit to you that an AHP that tries to be nicer than that would end up with their low cost members going elsewhere within a state that allows loose rating rules.

We had in Illinois actually a business association that tried to put up a consumer choice purchasing group. They started in the Chicago area. It was the manufacturers association, a very important, very powerful, very large membership with a lot of resources group. You know, they tried to be better than the market on this very issue. They failed.

Ms. LEHNHARD. I think that is a fundamental point. What our CEOs have said is we cannot operate in a market that has two sets of rules. A very typical example might be a Blue Cross and Blue Shield plan might have a small group market pool, and they might be the insurance carrier for the chamber of commerce in that state, an insured product.

If this passes, we would still be the insurance company for the chamber, but the chamber group would not have to cover substance abuse, ADHD, mental health, any of the state mandates. What would start to happen if they did not cover those mandates is people would jump back and forth when they needed the benefit because the HIPAA law says you can move without any waiting period.

So you stay in the chamber coverage. If you need substance abuse or someone in your family does, you are not penalized be-

cause as soon as you need it you can jump back into the state insured pool.

Our CEO said we cannot keep it affordable for the people who for whatever reason cannot get into the association or do not want to join the association because they need the mandated benefits. We cannot keep it affordable for them if we start splintering the pools these ways.

Chairman MANZULLO. I appreciate that. I am way over my time.

Mrs. Velázquez? I am sorry I took too much time, but they were great answers.

Ms. VELÁZQUEZ. That is okay. Thank you.

Chairman MANZULLO. It is very complicated.

Ms. VELÁZQUEZ. Thank you, Mr. Chairman.

Ms. Lehnhard, you make reference here to the 2000 CBO report throughout your testimony. Are you aware that when we conducted a hearing last February, February of 2000, they recognized that the report was fundamentally flawed, and is it not true that the CBO report did not specifically evaluate AHPs alone, but all types of group purchasing arrangements?

Ms. LEHNHARD. I actually testified at that hearing, and we followed up with CBO afterwards. What they said in the hearing did not affect their numbers. We have checked with them very closely. They are the same numbers.

Ms. VELÁZQUEZ. So they came here before our Committee and they said that they recognized that it was fundamentally flawed, and you say that it does not affect what they stated in the report?

Ms. LEHNHARD. It was a very confusing discussion in the hearing. I can follow up with you, but they are still saying that the numbers from AHPs for increased insurance is only about 300,000.

Ms. VELÁZQUEZ. Ms. Lehnhard, we have been meeting with a lot of doctors who are small businesses because doctors in private practice are small businesses. For years they have complained that many times their treatment decisions are determined by an administrative executive of an insurance company not to be medically necessary. As a result, an insurance company refuses to provide or pay for such services.

Do you oppose putting the decision making authority back in the hands of doctors?

Ms. LEHNHARD. This is probably the most difficult question——

Ms. VELÁZQUEZ. I know.

Ms. LEHNHARD [continuing]. In health care. Our concern is I will give you an example in Medicare. I worked on the ways and means committee for eight years, and we constantly had issues like Medicare eligible would want B–12 shots.

There are millions and millions of people who would like to have B–12 shots because they make you feel better. Medicare had to say the only time it is medically necessary is if you have pernicious anemia. Otherwise Medicare would be paying for all these B–12 shots.

There has to be some tension in the health care system so that we do not pay for things that are not tested, are not clinically proven or certainly are clinically proven not to be necessary or people are not going to be able to afford coverage, but it is a very difficult issue.

Ms. VELÁZQUEZ. Are you in insurance clinically trained to make those determinations?

Ms. LEHNHARD. First of all, only physicians make those determinations, and we use guidelines. We work rigorously with the different medical specialties. We are very well known in our tech program for developing guidelines with medical specialty groups on what is now a range of such complicated medical procedures that physicians—it is very difficult for them to stay up on what the new technology is and whether it is effective for what conditions.

Ms. VELÁZQUEZ. Let me ask you a question about fairness. Doctors can be held liable under state law if the decision causes harm to the patient while the insurance company escapes liability. Why should doctors be liable for decisions clearly made by insurance companies?

Ms. LEHNHARD. You know, you can argue the debates of this all day, but I think the fundamental bottom line is our system is voluntary in the United States, and we depend on employers to offer coverage voluntarily.

I can envision a board room if liability for employers passes, board rooms all over the country saying we cannot explain to our stockholders you being in the business of exposing the company to hundreds and tens of millions of dollars in liability. We are going to cash out employees and send them out on their own.

You know, you can argue the merits, but the problem is we are based on employers stepping up to the plate and doing this voluntarily, and you just heard that it would be very difficult, particularly for small employers, to do this if they have the exposure of liability.

Ms. VELÁZQUEZ. This is going to be a long debate.

Ms. LEHNHARD. It is a long debate.

Ms. VELÁZQUEZ. Ms. Trautwein, in your testimony you say that the proposal could be administered through the employer. Will this increase additional administrative burdens on small business owners?

Ms. TRAUTWEIN. No, I do not think so. There are actually two different ways that it could be done, just to give you some examples.

There are some credits that are available already that are done in the way I am going to suggest first, and that is the employer advances the amount of the credit the employee is eligible for on his paycheck, and then when employers do that every time they have a payroll they have to make a tax deposit. From that tax deposit they simply subtract out the amount of any credits that they have advanced to eligible employees. It is not reinventing the wheel. They do this already.

Second, in the economic stimulus bill that passed the House there was a provision for transfers and people receiving certificates through unemployment offices. That is an idea that could be modified so that if there were any sort of a cash flow situation what would happen is the employer, when remitting their premium, would remit their premium less any tax credit amounts and give the names and eligibility numbers directly to the insurance company, and the insurance company would be wired the money in a few days.

Ms. VELÁZQUEZ. Can you explain how affordable the health insurance for low income workers would be if the employer does not provide and does not make a contribution?

Ms. TRAUTWEIN. Most states in terms of group plans require—in order for them to be categorized as group plans require some degree of employer contribution, so I think that that is dependent on—small business people generally cannot afford to make the level of contribution that some of the larger employers can.

I know we are off the discussion of the underwriting pools and everything, but that partly has to do with why a group of 10,000 people made up of small employers is different than a group of 10,000 people that work for one.

I know that is not what you asked me now, but we are dependent on employer contributions. We have to have employers continue to do that, but it is just not enough for some of their low income people. That is why we need some help with that.

Ms. VELÁZQUEZ. Thank you, Mr. Chairman.

Chairman MANZULLO. Thank you. This is pretty confusing.

I would like to go to Mr. DeMint, going out of order with Mr. Grucci.

Mr. DEMINT. Thank you.

Chairman MANZULLO. Mr. DeMint, please? Then, Mr. Grucci, we will come back to you.

Mr. DEMINT. Thank you, Mr. Chairman. You mentioned employer contribution, and I would like to follow up on that. I do apologize for being late.

As soon as I ask my question, I am going to have to leave, but I would like to throw another idea in the mix because I think we will all agree that the more choices we give employers and employees to put money into this purchase of health insurance and purchase of health care the better off we are. I will address my question to is it Ms. Trautwein?

Ms. TRAUTWEIN. Trautwein.

Mr. DEMINT. Ms. Trautwein, in your testimony you recognized that there are 40 million Americans that are uninsured. About 25 million of those work for companies that just do not offer insurance.

I like your idea, and I think others do, too, of the refundable tax credit idea to get the employee, the individual himself or herself, involved with paying for health care, paying for health insurance or even using that credit to offset the cost of an employer plan.

There is another idea in the mix related to an employer contribution that I would just like to throw out, get your response to, and maybe you can discuss after I am gone, but the idea of allowing an employer to put money into a health expenditure account or a health 401(k) for the employee to purchase health insurance and health care.

The employee could add to that with the idea of a refundable tax credit if they wanted to, but we want to encourage these employers that do not offer health insurance now to put money with the same tax treatment that they get if they did offer a benefit.

As a small employer myself, I know that dealing with the administration of a plan and purchasing small group plans, the fact is that in my company of under 20 people the individuals could have

bought better policies on e-health insurance for less money than I was paying for a group policy, and it would have been easier for me to give them money and let them own their own plan with some changes in the regulations so that those plans would not be considered group plans.

What do you think of the idea of an employer having the option of contributing money to an employee's health expenditure account? Is that something you have considered?

Ms. TRAUTWEIN. Yes. We have actually thought quite a bit about this, in fact.

So what you are suggesting is they take funds from this account and purchase like a policy from an insurance broker or on e-health and wherever in the individual market?

Mr. DEMINT. Right. Use some of the money for a base health plan. They would have to do that at least in the bill that we are talking about. The rest of the money could accumulate, roll over, and they could buy their basic health care with it, as well as have a backup insurance policy.

Ms. TRAUTWEIN. Okay. Let me characterize this very carefully because I do not want it to come across the wrong way.

The individual market is a very important resource for very many people. A lot of people can get good coverage there, but everyone cannot buy there. The individual market is medically underwritten in most states. We have done extensive studies and research on this market across the country. Although you can go to e-health and pick out a policy, you still have to go through medical underwriting in most states. A lot of people do not make it through underwriting, and that is the honest truth.

You do not necessarily have to have cancer to have a problem being underwritten on an individual policy. It can be as simple as having chronic allergies or controlled asthma, controlled high blood pressure, 20 pounds overweight. It does not have to be something terrible. That is my concern about just all of a sudden just dumping people out and that is the only place that they have to go because of that problem.

So what happens? When they apply for those policies, one of three things happens. They either get a very large rate up—it can be like 50 percent or more; sometimes it is only 25 percent if it is something minor—or they can have a rider, and that is very frequent, where a certain condition can be ridered out.

For example, let me tell you what a rider would be. This is important. Let us say that you had had a strained back. A rider might be a rider on anything that happens to your back. This is fairly common.

The third thing is they could be turned down altogether. In many states, and fortunately we have 28 states that have high risk pools, those people would have somewhere to go at a controlled cost, but they may not be able to have exactly the same benefits that they would have had if somehow the employer would have offered a plan. That is our concern.

Mr. DEMINT. My hope is that ideas like association health plans will offer different products that individuals could also buy from too, but the thought is that the individual would still be better off

in the open market than having no insurance at all from their employer again as an option.

I would like to contact you with some of the research that you mentioned on the individual plan market.

Ms. TRAUTWEIN. I would love to talk to you about that.

Mr. DEMINT. Thank you, Mr. Chairman.

Chairman MANZULLO. Would you talk about your bill?

Mr. DEMINT. This is a bill designed for employers who do not make a contribution to employee benefits—basically to allow them to make a contribution that could only be used for health insurance and health care. It is really focused on small employers, those 25 million individuals who work for companies that do not offer insurance, to try to stimulate the individual market to a degree, but not to replace group benefit plans offered by employers or not to conflict with association health plans.

The thought again is we have a problem with the uninsured. If employers are willing to put some money into a plan or that the individual can own and accumulate, and it is just like a 401(k) for health care, then this is just an additional option. The thought is we are not going to replace current benefit plans, but the fact is with the cost of insurance, the erratic changes in the cost of insurance, small employers have a very difficult time purchasing small group plans, keeping up with the expenses.

As we look more and more to adding liability to that, they are going to dump off in droves. If they are spending $500 a month on a health plan for their employees, rather than get out of health insurance completely if they decide I would much rather see them put the money in a health expenditure account and allow them to at least try to buy on the open market, but then as we push for things like association health plans or other ideas that aggregate risk over a larger number than just an individual or an employer, we create another option.

Mr. Chairman, that is the hope is that we can look at all segments of the market and try to encourage employers that do not offer a benefit plan to at least put money into an account.

Chairman MANZULLO. What I would like to do is have a lot of hearings at the full Committee level on this. What I would encourage you to do, Congressman DeMint, is to meet with one or more of the people here. There is an obvious desire to insure more people.

Mr. DEMINT. Exactly.

Chairman MANZULLO. Ms. Lehnhard, you know, does not like AHPs, but that is okay. She has given some very good reasons for that.

Mr. DEMINT. Right.

Chairman MANZULLO. She has also stated there is a desire to insure more people at rates they cannot afford.

At the next hearing, I would be interested in knowing what Blue Cross/Blue Shield, which is the largest provider in this country, what their views would be on what may be an alternate plan to AHPs. We are looking for anything that would work here.

Thank you for your time.

Mr. ARTH. Mr. Chairman, if I may?

Chairman MANZULLO. Sure.

Mr. ARTH. Congressman DeMint, your comments and Ms. Trautwein's response really go to the point we were trying to make earlier with respect to MSAs. Because MSAs are a group product, it addresses some of the access issues that Ms. Trautwein mentioned with respect to people who do not have perfect health.

At the same time, it is a high deductible, lower premium plan which makes it much more affordable. It is based on the premise that the employer and employee, but currently not both, could make a tax advantaged contribution into a spending account dedicated for health insurance, and it is the reason that we really believe that is a solution that is on the table, but just has not been properly executed.

Mr. DEMINT. Right. Thank you.

Chairman MANZULLO. Thank you.

Congressman Davis, my colleague from Illinois?

Mr. DAVIS. Thank you very much, Mr. Chairman. Let me commend you for holding this very terse, insightful, thought provoking hearing.

As a matter of fact, the more I listen the more convinced I am that the only way we are going to really get to the bottom of the problem is to ultimately have a national health plan. I suspect that there are lots of people who are in disagreement with that.

The question, and anybody can respond, is for those individuals who have 20 employees or 25 employees with the employees earning $12 an hour or $10 an hour. Is there any way that you see either the employer or the employee being able to afford a health plan that can be put together that would give them adequate protection?

I understand the complexities of the business. I understand the economics. I understand all of it. I still have not seen anything yet that provides for that group of individuals that I just laid out.

Mr. ARTH. Congressman Davis, my assemblers, which represent the majority of the employees in our company, currently I believe the ceiling rate is about $9 an hour, give or take a little bit. They have access to four different plan choices, employer sponsored.

We pay, depending on the number of dependents, 75 to 95 percent of the premium. Virtually every employee participates with the exception of those who have better coverage available through their spouse's employer.

I think it is getting into the target area you were talking about. The participants in the COSE plan are smaller companies. The average plan size has 6.2 subscribers, and a lot of those companies are not particularly high wage companies. I mean, it can be done so I would not throw my hands up and say the only choice is to go to a national health plan.

Mr. DAVIS. You pay part of the premium?

Mr. ARTH. Yes, sir. We pay the majority of it. Yes, sir.

Mr. CURTIS. Mr. Davis, as you clearly know, most employers like you just described cannot afford to pay 90 percent. Many of them cannot afford to pay 50 percent of existing rates. However, many of them can afford to contribute something. Our best guess is they could contribute maybe 25 percent of premiums.

There need to be public subsidies, be it from a state CHIP program or from a tax credit that helps the individual out substan-

tially. There are some small demos actually within the very limited foundation dollars available. There is one in San Diego run by the Sharpe Health Plan which is structured like that.

The amount the individual contributes actually slides based on family income. There are others that are based on wage like one in Wayne County, so there are a couple models out there that very generally described fall into that category, and they seem to work quite well. They quickly fill up.

There are several others. There may be one announced today announced by a governor in a New England northeastern state, a demonstration that would be bigger than the ones I have mentioned, but I think that kind of a structure does have substantial promise.

All you have to do is look at the data. Employers under a size of ten who have a majority of workers making less than $6.50 an hour, which happens to use what a national survey uses as a threshold, only about 19 percent in 2000 offered coverage, and 81 percent by definition did not.

That is better than it was a couple years before. Employers like you have described typically cannot afford traditional contribution requirements.

Mr. DAVIS. Thank you.

Mr. MUSSER. Congressman, on behalf of NFIB and the coalition of small business organizations that support the association health plan bill, we would urge you to take another look at that in the sense of achieving the goals that you are looking at.

Going back, to give you an example, to the example that Chairman Manzullo put forward with a small business getting a 45 percent increase in their health insurance premium, large businesses are not getting those types of increases. It is small businesses normally with less then ten or 20 employees that are getting hurt.

What we are looking for is to work on a bipartisan basis to give small businesses the same types of tools that large companies and labor unions have used for many years. We have tried to work with all groups on this over the last few years.

This has not been tried in the current form that the bill has been proposed, so we think it is the most effective way to go in the direction that you want to see where we have more access to health insurance for small businesses.

Mr. DAVIS. Thank you very much.

Chairman MANZULLO. Are you going to be able to come back, Congresswoman Tubbs?

Mrs. JONES. No, I am not. I was hoping I could have a chance, at least two or three minutes, from Mr. Grucci.

Chairman MANZULLO. Could you guys work together so we can still go down and vote and finish up?

Mrs. JONES. Yes. We will be short.

Chairman MANZULLO. Go ahead. Both of you ask questions in whatever order you want. Felix, you would be next, but you were here way at the beginning, so however you want to do it.

Mr. GRUCCI. With deference to the senior Member, I will——

Mrs. JONES. Oh, I love to hear that. It has taken me a long time to be more senior than somebody on this Committee.

Chairman MANZULLO. With only a year on the job, you have to be more senior now.

Mrs. JONES. Thanks, Mr. Grucci. I will be brief.

What I would like to do is give Mr. Arth an opportunity to make any other commentary since he came all the way here from the City of Cleveland with regard to the COSE proposal.

Let me ask you, and then you can talk about whatever else you would like to. I will restrict comments to three minutes. That way it will give you a chance.

Can you assess your increased costs or your annual increased costs for the plan that you provide for your employees, sir?

Mr. ARTH. Do you mean for this coming year, ma'am?

Mrs. JONES. Yes. Generally, what is the average increase?

Mr. ARTH. Well, actually during the 1990s we had a relatively stable period. We had a couple years with increases as low as two percent or thereabouts. Last year, as I say, we ended up settling at 12 percent through plan changes.

Those options are gone this year, and we are expecting a very sizeable increase. I would guess 20 percent or higher. It is going to be a real challenge for me in terms of how much of that can the company pick up, and we are obviously going to have to look at additional cost sharing with our employees on that.

Mrs. JONES. Make a suggestion before a panel of Congress with regard to small businesses as to what we could do to help you bear that 20 percent increase.

Mr. ARTH. Our group has access to all the data regarding utilization. We know where all the dollars are going. If we want to get control on health care costs, we have to control utilization—hospitals, drugs and so forth.

As I said earlier, and I will not beat this to death, one of the problems is other people's money. That is part of the reason we pushed the MSAs because it gets the consumer of health care more involved with paying for what they are getting. We think there will be better choices. I will not beat that further at this point.

Chairman MANZULLO. Mr. Grucci.

Mr. GRUCCI. Thank you, Mr. Chairman. I do have an opening statement, and I will ask if I could submit it and it be made part of the record.

Chairman MANZULLO. It will be made part of the record.

Mr. GRUCCI. Ms. Lehnhard, the question that I have I will get right to. In New York state we have over three million people who are uninsured. We have health care providers that are evacuating out of counties because of some of the things that you mentioned earlier—reimbursement rates, et cetera. Blue Cross was not one of them.

As a result of the increase in customer base that it got, it also raised rates considerably. I was questioning why with the increase in new enrollees coming from other health care plans would there be a need to raise rates in some instances as much as 40 percent?

If you do not believe that the health care plans and the medical savings associations are the right way to go, seeing that what we currently have in place is costing itself out of the marketplace and out of the reach of small businesses and employees, what would your suggestion be to fix the problem?

Ms. LEHNHARD. Let me address the increase in cost first. Now, I mentioned this 16 percent increase in hospital costs, which is enormous. That is the bulk of our spending. What you have to do is not only catch up for those unanticipated increases; you have to collect money for the future to build up your reserves because your reserves are going down faster.

Also, in a small group market even though you have a giant pool, if you have a big employer he is going to cover everybody. When you get to the small group market you are going to have employers that do not offer coverage unless their employees are really sick. When you get to the individual market, you have the worst case that people only buy insurance when they really need it.

As you move down that continuum—large group, small group, individual—you have sicker and sicker people, so when health care costs go up you multiply the effect because you have more people using health care costs in a small group pool as compared to the large group pool.

Chairman MANZULLO. We are out of time. I know you did not finish your answer. I am very much interested in it. If you want to put that in writing and give it to us, we are very much interested in it.

We have to run off to a vote. The Committee hearing is adjourned.

[Whereupon, at 11:40 a.m. the Committee was adjourned.]

House Small Business Committee
Hearing on Small Business Access to
Health Care
February 6, 2002

Opening Statement
Chairman Donald A. Manzullo

Good Morning. I would like to thank all of the witnesses for coming here today to discuss the crucial issue of small business access to health care.

Exorbitant health care costs are one of the biggest expenses small businesses and the self-employed incur as they struggle to provide coverage for their employees. As Congress continues to examine our nation's health care problems, we need to remember that sixty percent of the estimated 43 million uninsured are small businesses owners, their employees and families.

Small business owners are unable to absorb spiraling health care costs and find themselves priced out of the health insurance market. Many owners are faced with the choice of staying in business or providing their employees with insurance.

I personally know of a small business owner who pays $700 a month and has a $5,000 deductible to insure both himself and his wife. He and his wife are considering selling their business and taking jobs that would pay considerably less in order to receive health care benefits.

Our current health care system does not provide equal access to affordable and quality healthcare for small businesses.

Corporations have a myriad of advantages when it comes to providing their employees healthcare -- from 100 percent tax deductibility of healthcare premiums, to large pockets to absorb costs as well as the ability to buy health care at reduced-rates based on volume, corporations have advantages that their small business counterparts desperately need.

I am very supportive of Representative Fletcher's bill that allows for the creation of Association Health Plans or AHPs. AHPs allow businesses to come together and pool their resources through professional associations. This will allow them to enjoy the same economies of scale that large corporations or labor unions enjoy. It would also allow for self-funded health coverage plans modeled after labor union plans.

I can't help but wonder why insurance companies cannot offer affordable healthcare to small businesses? Why must insurance companies charge the most to those least able to pay these inflated prices?

We cannot continue to stand by and watch as small businesses find themselves priced out of the insurance market.

I look forward to the testimony of all the witnesses here this morning and I want to particularly thank those who have traveled a long distance to be with us here today. I now yield for an opening statement by my good friend and colleague, Representative Nydia Velázquez of New York.

STATEMENT
by the
Honorable Nydia M. Velázquez
House Small Business Committee
Hearing on Small Business Access to Health Care
Wednesday, February 6, 2002

Thank you, Mr. Chairman. I appreciate your initiative in calling this hearing on such an important subject.

We have a health care crisis in this country. Today, 40 million Americans – or one in seven, almost 15 percent – do not have health coverage. The number has dropped in the past couple of years. It is still unacceptably high, and I fear the slowing economy will swell the ranks of the uninsured again.

The great majority of Americans get health coverage through their employer. There is a reason for this. Companies, especially large ones, can bid on the best deal to contain costs. It is not surprising, then, that only 42 percent of companies with fewer than 100 employees provide health coverage for their workers, while 95 percent of companies with more than 100 employees provide health coverage.

In fact, 60 percent of uninsured people – 24 million Americans – live in families where the head of the household works for a small business! Self-employed people account for 10 million uninsured Americans, including two million children.

Most small business owners would like to provide health coverage for their employees and their families, but they are restricted by cost. This is the main reason why health care coverage was named as one of the top 11 small business issues for this Congress in a report the Democrats released last month. These companies want to provide health coverage for their employees, but can't.

This is not a one-size-fits-all proposition. No one solution would cover the entire diversity of small businesses. Nonetheless, we have two strong proposals that can help these companies help their workers.

First, we can accelerate the 100 percent deductibility of health care premiums. We are now at 70 percent, with the full 100 percent coming nearly two years from now. But there is no reason why we shouldn't make that 100 percent available right now. I hope we can work together to put this powerful incentive into effect immediately.
Another proposal is the Association Health Plan, which could allow small businesses and the self-employed to band together in industry-specific groups and leverage their collective strength to provide better and more affordable health care options than they would alone.
AHPs could level the playing field, putting small business purchasing and bargaining power on par with their corporate counterparts. It would be a hedge against precipitous price hikes that make it difficult for small businesses to continue offering health benefits when they have them.

AHPs and 100 percent deductibility are just two very good possibilities. Still, there are other options to learn about. That is the purpose of this hearing.

But I think we should keep one ultimate goal in mind while we listen to our witnesses and various new policy proposals. Our goal must be to continue expanding the number of American working families with health care coverage. It is the right thing to do, for our country and our future.

Thank you very much.

"SMALL BUSINESS ACCESS TO HEALTH CARE"

Hearing in front of
The House Small Business Committee

February 6, 2002, 10:00 a.m.

2361 Rayburn House Office Building

Testimony of Congressman Ernie Fletcher (KY-06)

Thank you Chairman Manzullo and Ranking Member Valazquez and the all the Members of this Committee, for inviting me here today to testify. As many of you know, I introduced H.R. 1774, the Small Business Health Fairness Act, on May 9, 2001.

Let me take a moment to note that there are 12 members on this Committee that are cosponsors of H.R. 1774, including the Chairman and Ranking Member. Also, 18 of you on the Committee voted for the AHP amendment to the Patients Bill of Rights. As you know, this amendment passed the House and is included in the final House version of the bill. Thank you for your support.

America's growing healthcare dilemma, calls for immediate presidential and congressional action. We must address the fact that too many Americans lack health insurance. Experts estimate that at least 38 million Americans are currently without health insurance. Additionally, the recession and terrorism of Sept. 11 have increased the ranks of the uninsured by an estimate of one million people. The uninsured include some of the most vulnerable in our society--12 million children, 17 million low-income Americans, 7 million African-Americans and 11 million Hispanics.

Those without health coverage confront barriers that discourage preventive care and delay disease diagnosis. They are more likely to be hospitalized for avoidable conditions. In fact, last year, nearly 40 percent of uninsured adults skipped recommended medical tests or treatment and 20 percent did not get needed care for a serious problem. Consequently, studies reveal that morbidity and mortality rates among the uninsured are substantially higher than among those with health insurance.

As double-digit health premium increases and a weakened economy put more and more small business workers in jeopardy of losing their health benefits, we must turn our attention to the problem of the uninsured early in 2002. In light of the ongoing discussions between the President and the Senate regarding Patients Bill of Rights, it is critical that the final bill take action on comprehensive small business health insurance reform. I feel strongly that this should include enactment of the Small Business Health Fairness Act of 2001 (H.R. 1774), bipartisan legislation approved by the House as an amendment to the Patients' Bill of Rights (H.R. 2563) on August 2, 2001.

I fear that the number of uninsured Americans will increase dramatically over the next few years, if we don't act now. The Small Business Health Fairness Act would address this problem by creating new Association Health Plans (AHPs) for workers employed in small businesses and the self-employed. This bill, will provide working families employed by small businesses, which make up 60 percent of the uninsured, with more health benefits and more health plan choices.

Lacking the bargaining power of large corporations, many of these businesses are priced out of the health insurance marketplace, reluctantly leaving their workers uncovered. AHPs address this problem by allowing small businesses to band together nationally into associations that can provide insurance to their members at lower cost.

Small businesses and the self-employed do not have the same advantages in the market place as do corporate and labor union health plans. In fact, small employers now pay 18 percent more for coverage than large employers. Moreover, corporate and union health plans operating under one set of rules, across state lines, are able to take advantage of the economies of scale.

As you may know, the three main arguments against AHPs are: 1) Adverse Selection (cherry picking); 2) Inadequate solvency standards, and 3) inadequate oversight Enforcement.

Let me address these myths regarding AHPs:

First, it is illegal for AHPs to deny coverage based on the health status of an individual employer or employee under HIPAA. "Cherry picking" is possible only when sick or high risk people who will generate significant claims can be denied coverage;

Secondly, the bill contains strict requirements under which only bona fide professional and trade associations, which exist for substantial purposes other than providing health insurance for at least three years, can sponsor an AHP. The bill strictly prohibits health plans that are set up only to offer health insurance, or accept only good risks;

Thirdly, to the extent that low and high risk industries can be identified, the bill only allows new self-funded AHPs in industries with average or above average risk profiles, thus preventing self-funded AHPs from forming in low risk industries;

Fourthly, Opponents' allegations about adverse selection rest on the mistaken assumption that small businesses will only offer "bare bones" benefit packages through AHPs. However, small business owners and workers desire the same benefit packages as large business workers, and small businesses must offer comparable benefit options to attract and retain employees;

Fifthly, adverse selection that currently exists in state markets will be greatly reduced when younger, healthier workers employed in small businesses who are now uninsured are able to obtain coverage that is affordable;

The Small Business Health Fairness Act of 2001 (SBHFA) (H.R. 1774/S. 858) contains tough new solvency provisions which will actually increase consumer protections for many small business workers. The Department of Labor's Inspector General has testified before Congress that the new enforcement tools for regulators contained in this legislation will help reduce health insurance fraud. The bill gives federal and state authorities new and better enforcement tools to ensure that coverage is secure and to prevent health insurance fraud:

- Only long-standing, bona fide associations meet the bill's strict eligibility requirements, and are independent of insurance companies;

- Tough, new solvency standards require: claims reserves certified by a qualified actuary; minimum surplus reserves; both specific and aggregate stop-loss insurance, and indemnification insurance to ensure that all claims are paid;

- AHPs must register with the state in which they are domiciled;

- AHPs must abide by strict disclosure and actuarial reporting procedures; and,

- The bill provides new criminal and civil penalties to combat fraud.

Allegations that health coverage obtained through AHPs will be anything less than secure ignore these strong protections contained in the bill. AHPs are fundamentally different from Multiple Employer Welfare Arrangementsor MEWAs, which generally will not qualify as AHPs under the new certification process.

Association Health Plans (AHPs) would be regulated in a manner similar to how single employer (corporate) and labor union pension and health plans are currently regulated. Thus, the bill does not require an entire new bureaucracy to ensure that AHPs are properly regulated.

- The DOL already regulates association-sponsored health plans for compliance with current federal laws governing group health plans. The SBHFA strengthens solvency standards and certification rules to plans operated by qualifying bona fide trade and professional associations.

- DOL is devoted to identifying, investigating and disbanding fraudulent MEWAs. This is the case for many state insurance departments as well. Since the bill provides new enforcement capabilities that will assist DOL and state insurance departments in identifying and shutting down fraudulent MEWAs and preventing new ones from getting started, resources can be redirected to the regulation of bona fide AHPs under new standards in the law.

- The bill provides that associations applying for certification as a federally-regulated AHP must pay a $5,000 filing fee, which will generate resources to enhance enforcement of the new law.

- The bill allows the Secretary to consult with the states in regulating AHPs, and provides that new self-insured AHPs be subject to the assessment of state premium taxes or equivalent assessments, thus providing resources that can be used for regulatory responsibilities.

- The bill gives DOL enhanced criminal and civil enforcement powers currently not available to stop health insurance fraud by terminating bogus small employer and union health plans. Illegitimate entities will become criminal enterprises, and DOL will have new "cease and desist" authority to curtail such activities. The DOL

Inspector General has testified that the bill's consumer protections are "important and necessary in stopping health insurance fraud."

It is only fair that we should level the playing field and allow small businesses and the self-employed access to the same opportunities in health insurance coverage that large corporations and labor unions now enjoy. The Small Business Health Fairness Act included in the House passed Patients Bill of Rights would rectify this inequity by providing small businesses with similar opportunities to operate health plans under one uniform set of rules via bona fide trade and professional associations. This would provide workers with the benefits of greater economies of scale, more bargaining power with large insurance companies, reduced administrative costs and greater benefit design flexibility. These bills will also inject competition into markets where it is severely lacking, thus further reducing premiums for workers. One independent study has concluded that AHPs could reduce premiums by up to 30 percent and estimated that up to 8.5 million uninsured workers and employed by small businesses and their dependents would gain coverage if Congress enacts this legislation.

It is past time to pass the Patients Bill of Rights bill, including the Small Business Health Fairness Act, for the President's signature. The content of this compromise could not be more important. The final patients' bill of rights must contain provisions to improve access to affordable health insurance for all Americans. The legislation will be a Pyrrhic victory if more Americans become uninsured due to the inevitable cost increases resulting from HMO reform. Only the House-passed legislation properly addresses the health threat of rising cost and decreasing access, especially to the most vulnerable of Americans.

I can't stress enough that delaying this issue continues to hurt the most vulnerable Americans. The Patients Bill of Rights should become law, but not without AHPs. The most important patient protection is access to affordable healthcare coverage. As David Broder wrote recently, HMO reform alone "is likely to increase cost and could even aggravate the problem of wasteful expenditures for services of little or no health value by forcing HMO doctors to practice 'defensive medicine' to ward off lawsuits." We will do a terrible disservice to the American people by passing a bill designed to "protect" patients that ends up leaving millions of our fellow citizens "unprotected." We cannot be willing to hurt the most vulnerable - minorities and low-income folks - in America for the hope of a political victory.

I appreciate your inviting me to testify today and allowing me to continue to call attention to this problem through these hearings. I look forward to working with you to achieve this objective.

Testimony of

Elaine P. Smith, President
E. Smith & Associates

before the

House Committee on Small Business
Small Business Access to Health Care Hearing

February 6, 2002

Good morning Mr. Chairman and Members of the Committee. Thank you for inviting me from Illinois today to talk about the important issue of affordable, accessible health insurance, especially for those owning or working for small businesses. I am pleased to be here on behalf of the National Federation of Independent Business (NFIB), representing 600,000 members who face a similar challenge.

My name is Elaine Smith, and I own E. Smith & Associates, a promotional marketing and fulfillment company based in Granite City, Illinois, just across the Mississippi River from downtown St. Louis. At E. Smith & Associates, my employees and I work together to develop, market and sell point-of-sale displays, corporate merchandise and other items. For Ralston-Purina, my company has fulfilled over four million "How to Raise a Healthy Puppy" kits that are marketed to veterinarians and veterinary schools.

E. Smith & Associates was born out of an opportunity to become an outside vendor for various Anheuser-Busch marketing projects. At the time, I was employed by Anheuser-Busch, but in 1986 left the corporate world to work out of my basement with just one

employee. Since then, E. Smith & Associates has grown to employ 12 full-time workers, approximately 80 temporary workers and to occupy three warehouse facilities. My employees range in skill level, from high school graduates to college graduates, in age, from late teens to mid-fifties, and earn an average salary in the range of $25,000-$30,000.

Like many entrepreneurs, I learned early that I could not compete with large corporations in the area of extensive benefit packages. Instead, when hiring employees, I offered "perks" that big companies could not – flexible and individualized schedules, the chance to move up the skill ladder quickly, and so on. For many years, I did not offer health insurance as a benefit. In fact, having come out of the corporate world, I truly had not given much thought to health insurance at all. It was standard in the work arena from which I had come, and I hadn't ever stopped to think about who was paying for that benefit or how much it might cost. However, in recent years, two experiences forced me to stop and think about health insurance and what role an employer should play.

First, I began to realize that my small business attitude and start-up perks weren't enough to attract and retain talented, highly educated workers. At E. Smith & Associates I run a formal college internship program, providing marketing experience to students from Ball State University. Ideally, I like to hire these interns after they graduate. However, when former interns began to turn down my employment offers because of the lure of the benefit packages offered by larger competitors, I quickly realized that I needed to increase the types of benefits I offered, namely health insurance.

The second experience was more personal than business. A good employee who had been with me for some time experienced a series of common ailments – sinusitis, sore throat, cough, and flu. She just couldn't seem to get well. Even so, she showed up for work nearly every day. She wasn't productive, she ran the risk of infecting others, and she clearly needed a good dose of common antibiotics and a few days rest to revamp her immune system. When I approached her about taking time off to visit a doctor, I was stunned to learn that a doctor's visit was something she considered a luxury, something that was done only for serious or emergency medical problems – cancer or a broken bone. As I said earlier, I had never given much thought to the out-of-pocket cost one may have to pay for a simple doctor's visit and pharmacy bill. If I was sick, I simply made an appointment, saw a doctor and filled a prescription. So it gave me tremendous pause to realize that there are many people in this country without insurance – 43 million according to the Census Bureau - that viewed health care in a very different manner. I sent my employee to the doctor at my expense - $100.00 for the office visit and $125.00 for the antibiotics. After literally finding myself in my employee's shoes by paying these bills, I decided that those who work hard for my company deserve the peace of mind that those who work for large companies enjoy – the ability to go to a doctor or fill a prescription without forfeiting a sizable chunk of one month's take home pay.

So last year, I decided to provide employer-sponsored health coverage. I knew that I wanted to provide a quality plan – medical, dental and vision coverage, with a wide network of doctors – and I knew that I needed to set parameters in order to afford it. I set an eligibility requirement of one year of service and a 50/50 employee-employer shared

contribution rate. In searching for a plan to meet these objectives, I was quite surprised to learn how difficult it was to find an affordable plan. However, I proceeded and began offering the benefit to four employees, as the other eight either were covered under a spouse or parent or did not yet meet the one-year eligibility requirement. Employees paid $125.00 per month, with an employee electing dependent coverage paying approximately $250.00 per month. My idea was to manage the first year's benefit, while developing plans to extend the benefit the following year so that as an employee's seniority increased so would the premium contribution paid by the company.

Everything seemed to be going smoothly. We budgeted accordingly so that more employees would be added to the plan at our annual renewal. Therefore, I was completely flabbergasted when I received my very first annual policy renewal statement – with a whopping increase of 26% for apparently no particular reason. Naturally, I contacted my insurance representative to inquire about the big jump in cost. I was told quite simply that double-digit increases were not atypical for small business owners, and, in his words, were "just the nature of the health care market."

My first reaction was to replace the current plan with something more affordable. However, after a preliminary search, I realized that in order to keep the quality of my plan, my choices were pretty limited. Knowing that providing health insurance is necessary to me for both business and personal reasons, and knowing that I can't increase prices to my customers an extra 26% in order to absorb the cost, I reluctantly renewed the policy.

Ironically, a few months before receiving the health insurance premium increase, I had taken another big benefit step and began offering long-term disability and accidental insurance. When nearly all employees signed up to participate, it reaffirmed my belief that insurance benefits are important to my workers. Therefore, I want to do my best to continue offering insurance benefits, but if I face 26% increases every year, it will become more and more difficult.

A recent bipartisan poll asked 1,000 Americans what worries them most about the economy. The top response -- overwhelmingly -- was "rising health-care costs," with nearly 1 in 3 people listing that as their top economic concern. We must all constantly remind ourselves that the true crisis in health care -- and in the economy as a whole -- is the skyrocketing cost of health insurance.

Those in the small business community who are insured are struggling each year to afford the cost of increasing premiums. It's for this reason that I support legislation endorsed by NFIB that would create Association Health Plans (AHPs). AHPs would allow small business owners to band together across state lines to purchase health insurance as part of a large group, thus ensuring greater bargaining power, lower administrative costs and freedom from costly state insurance mandates. Fortune 500 companies and labor unions already have this right. AHPs will simply level the playing field and give small employers the same privileges as their counterparts in labor and big business.
In addition, AHPs will introduce into the market place much needed competition and diversity. Without the ability to shop for more affordable options we are left with

shifting cost or dropping coverage. Association health plans would be a health care purchasing dream come true.

Eliminating the regulatory burden on medical savings accounts (MSAs) would also benefit small business. MSAs, without the current restrictions, would provide positive benefits to employees. They give employees control over their own health care decisions. Making MSAs more workable by easing the regulatory burden on them will provide yet another affordable health care option to small business.

Like most small business owners, I'm a networker. To be competitive on Main Street, you have to be. I seek out organizations that provide educational seminars and discounts on goods and services, and I know that AHPs and MSAs would be great options for small business owners like me. Now, I'm a salesperson, not a health policy expert, but I do know that there is much debate about how to insure more Americans and how to help those currently insured continue to afford their coverage. To me, AHPs and MSAs are good, common sense solutions to controlling the cost of quality health care.

Mr. Chairman, thank you for allowing me to share my experience with you and the Members of the Committee. I look forward to following the good work that Congress will hopefully do in relation to AHPs and MSAs, and I am happy to answer any questions that the Committee may have.

PREPARED TESTIMONY OF RAYMOND ARTH

PRESIDENT, PHOENIX PRODUCTS

ON BEHALF OF NATIONAL SMALL BUSINESS UNITED

Small Business Access to Health Care

Before the House Committee on Small Business

February 6, 2002

Thank you, Chairman Manzullo, Ranking Member Velazquez and members of the House Committee on Small Business for inviting me to testify today. I am Raymond Arth, the president of Phoenix Products, a producer of faucets for the manufactured housing and recreational vehicle industries. Phoenix is the largest single supplier of faucets to the Manufactured Housing industry and a major supplier to the Recreational Vehicle manufacturers industry. We have earned this position by providing innovative and cost-effective product designs to meet the specialized needs of our customers. Our company enhances its reliable product line with short lead times and excellent fill rates. In fact, our organization has been designed from the shop floor to its outside sales staff to provide our customers with reliable products and excellent service at competitive prices. I have about 60 employees and we are located in Avon Lake, Ohio.

I am a member and past chair of the Council of Smaller Enterprises (COSE), a division of the Greater Cleveland Growth Association, located in Cleveland, OH. Our offices are actually in the district of one of the members of the committee, Ms. Stephanie Tubbs-Jones. COSE represents over 16,000 businesses in the Cleveland area. Currently, nearly 14,000 businesses and 200,000 individuals receive health coverage through our group purchasing plan.

I also serve as the chair of the Legislative Action Council of National Small Business United, and am a member of its Board of Trustees. NSBU is the nation's oldest bipartisan advocacy association for small business representing over 65,000 small businesses in all fifty states. In addition to individual small business owners, our membership includes local, state and regional small business associations (such as COSE) across the country. Our association works with elected and administrative officials in Washington to improve the economic climate for small business growth and expansion.

I am pleased to appear before the committee to express our views on health care coverage for small businesses. Health care reform is very important to NSBU and its affiliates. In fact, health care reform is one of our top priority issues for the 107th Congress and has been a priority issue for our organization for well over a decade. We are committed to working with the Committee on Small Business to see that this goal is met.

Anyone who has read a newspaper, watched the evening news, listened to the radio, or in my case, owned a small business, knows that health care costs for small businesses are escalating at a rapid rate with no end in sight. Last year, faced with renewal increases up to 24 percent, we changed our plan designs and offered new coverage options. After choosing less expensive alternatives, we still incurred premium increases of 12% for

the majority of our employees. Buying through a purchasing group, my health insurance costs average only $175 per employee and $532 per family per month. In other areas of the country, it is not uncommon for family coverage in a small business to cost well in excess of $10,000 per year. Without reform, we can expect that insurance premiums will continue to rise at alarming rates. In order for small businesses to be able to provide their workers with health benefits, insurance costs must be contained and a level playing field in the insurance market must be created.

As a result of rising costs, many small businesses are often unable to offer adequate insurance coverage to their workers or are forced to drop insurance coverage altogether. In my case, I cannot pass these costs on to my customers, so I have to make tradeoffs between spending on health insurance vs. other benefits vs. new products or equipment, and so on.

But price is only one half of the problem. Access is the other. In many parts of the country, insurers aren't really interested in serving the small group market because the costs of selling and administrating the products make them unattractive.

Recently, a study conducted by the Government Accounting Office found that large and small businesses incur comparable premiums; but this does not translate into comparable coverage. Small businesses normally offer

plans that are less generous than those provided by large businesses. Further cost sharing in the form of deductibles, co-pays and employee contributions to premiums is generally much higher in the small business sector than for employees who work for a large company.

One of the fundamental problems with our health care delivery system is the fact that it runs on other people's money. The figures tell us there are 44 million uninsured Americans in this country, which means that about 85 percent of the population have health insurance paying for our care. The consumers of health care pay little, if any, of the cost for the services they receive. This has made us careless in our choices and has created an entitlement mentality in which we're trying to satisfy an insatiable desire for care unhindered by cost considerations at the point of service.

There are three major groups who finance health care costs in this nation: the government, large corporations that self-finance, and individuals or small firms that insure though traditional insurance companies. While the cost of health care is growing across all sectors, small businesses are especially hard hit for several reasons. Chief among them is the "cost shifting" that occurs when government programs, specifically Medicare and Medicaid, do not pay a fair price to the service providers. The unreimbursed costs incurred by Medicare and Medicaid providers do not magically disappear, they are

shifted to other payers, primarily in the insured market. Large companies have the ability to self-insure and have the clout to avoid the full impact of this cost shifting.

According to a December 18, 2001 article in the *Wall Street Journal*, many small firms have already begun to shift some health care costs to workers by increasing insurance deductibles. This is something that the small business community desperately wants to avoid, particularly since there is almost no tax-preferred status for out-of-pocket health care expenses. Keep in mind that I am not just an owner, but also an employee. My insurance benefits, along with all the contributions, deductibles and co-pays are the same for me as for my co-workers.

In addition, state mandated benefits are borne almost entirely by small businesses due to the ERISA preemption enjoyed by large, self-insured companies. Though well intentioned, these state mandates drive up the minimum cost of insurance and thereby increase the number of uninsured. Making low cost, no-frills coverage options available in the market would increase the affordability of health insurance.

An additional challenge facing small firms regarding health care is education. The health insurance market is far more complicated than it needs to be. According to a study by The Employee Benefit Research Institute

released in October of 2000, many small business owners are unaware of the tax advantages of offering health insurance. Over half of small employers did not even know that it is possible to deduct 100 percent of the health insurance premiums they pay on behalf of their employees. In fact, about the same number of small firms did not know that workers who purchase insurance on their own cannot deduct these costs, or that insurers are not allowed to deny health insurance to their workers even if the health status of the workers is poor.

To this point I have spent much time talking about the problems. Now let me switch gears. There are several things that can be done to make it easier for small businesses to offer insurance to their employees.

The first step is to fix the inherent problems with, and to expand, medical savings accounts (MSAs). Medical savings accounts are an excellent alternative to traditional insurance coverage because they turn the employees into paying consumers. Because the employee makes decisions about how their money is spent, they will be more prudent in their purchasing decisions and their utilization of health care. In fact, according to the latest IRS Announcement 2001-99 regarding Archer Medical Savings Accounts, 41.75 percent of those purchasing MSAs in 2000 were previously uninsured. The percentage of previously uninsured individuals purchasing MSAs has

continued to increase since the demonstration project began. Opening up the program to all Americans (Medical Savings Account Availability Act), as well as providing health tax credits to individuals could go a long way in addressing the problems of the uninsured.

However, some reforms to the MSA laws are desperately needed, as medical savings accounts are currently under-utilized. First, employers and employees cannot simultaneously contribute to the plan in a given year. Secondly, while 40% of employer plans involve Health Maintenance Organizations, MSAs cannot be offered because they involve high cost sharing. Also, medical savings accounts cannot be offered in conjunction with Section 125 plans. Because of these limitations, insurance companies are reluctant to structure MSA plans because they fear they will not be able to generate a fair return on their investment.

Another area that should be reformed is the rules for cafeteria plans. Presently, many employers do not offer cafeteria plans because the law prohibits sole proprietors, partners and owners who control more than two percent of a Sub-S corporation from participating. If employers are unable to participate in a plan, they are less likely to offer it to their employees. In addition, the "use it or lose it" provision of Section 125 plans scares some employees away and encourages discretionary and often unnecessary year-

end spending by participants with unspent funds. Finally, another way to aid small businesses is to allow for 100 percent deductibility of health insurance for the self-employed this year.

If we are serious about reform, we must be willing limit the role of litigation in the delivery of health care. Medical procedures are by nature risky, and our system must account for this risk. Of course we all want and expect quality health services and our legal system should provide remedies for incompetence and malpractice. But the reality is that the cost of lawsuits against health care providers is unnecessarily pushing up the costs and reducing the availability of health insurance.

The Patients' Bill of Rights is an example of well-intentioned legislation that will produce significant unintended consequences. According to the Congressional Budget Office, the Patients' Bill of Rights could drive up the cost of health insurance premiums by as much as 4.2 percent. Since every 1 percent increase in premiums translates into about 200,000 people dropping or otherwise losing their health insurance, a 4.2 percent increase works out to almost one million additional uninsured, without taking into account the effect of employer liability. Let me be clear, if offering a health insurance program exposes my company or me to potential liability, I will almost certainly discontinue any company involvement in health insurance

for my employees. Rather than offering more protection, the Patients' Bill of Rights will deprive more working Americans access to affordable health insurance.

I have made several references to the COSE group-purchasing plan for health insurance. This plan not only works in the Greater Cleveland area of northeast Ohio; we also manage the health care plans for the Toledo area chamber, the Mansfield chamber and a consortium of smaller chambers in the western end of the state. In total, almost 17,000 companies, 100,000 subscribers and about 250,000 lives are covered under our group plan.

We like to think that the COSE plan is one of the models that the Congress tries to imitate in formulating group purchasing programs. In this session there has been a great deal of discussion about Association Health Plans (AHPs) and their potential benefits to small businesses. However, based on our experience we have a number of concerns about this proposed legislation. Specifically:

- The Congressional Budget Office says that if AHPs are enacted, four out of five employees of small firms, or 20 million Americans, will see a rate increase. Only 4.6 million people will see a decrease.
- AHPs preempt consumer protection legislation such as financial solvency and reserve requirements enacted by states.

- ❖ AHPs that do not need to comply with state laws will create an uneven playing field, which may destroy local insurance markets. The potential risk selection problems are probably our greatest concern about AHPs.

There are many barriers for small businesses in providing health insurance to their workers. However, we believe that these barriers can be overcome and small businesses can make it possible for their workers to receive health care coverage.

Thank you for the opportunity to testify today. I would be happy to answer any questions you may have.

Serving the Needs of Small Business America for Over Twenty Years

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Testimony of

Robert E. Hughes

President of
The National Association for the Self-Employed

Small Business Access to Health Care

Before the House Small Business Committee

February 6, 2002

Mr. Chairman, Ranking Member Velazquez, and Members of the Small Business Committee, I would like to thank you for this opportunity to testify before you today to discuss small business access to health coverage.

I am Robert Hughes, a self-employed CPA currently residing in Texas. I am also currently President of the National Association for the Self-Employed (NASE), a bipartisan, non-profit small business trade association founded in 1981 that represents over 200,000 members nationwide. Ninety percent (90%) of our membership consists of small businesses with five (5) or fewer employees. The NASE's primary goal is to help the self-employed meet the challenges of making their businesses successful and one of the self-employed community's largest challenges is obtaining access to affordable health coverage.

Mr. Chairman, I would like to start off my testimony by citing various statistics of which I am certain the Members of this committee and witnesses of this panel are aware.

- There are approximately 24 million small businesses in our nation. They account for 99.7 percent of America's employers and employ 53 percent of the private work force.

- There are approximately 43 million uninsured Americans in our nation and that number increases as the unemployment rate increases. Approximately 62% or 24.5 million of the uninsured have a family head that is self-employed or working in a firm with fewer than 100

employees. (Source: Employee Benefit Research Institute data from the Census Bureau's March 1998 Current Population Survey)

- According to the General Accounting Office's October 2001 report on Private Health Insurance, only 36% of employers with fewer than 10 workers offered health coverage to their employees despite the fact that they represent about 61% of small employer establishments. The report cited the primary reason small employers gave for not offering coverage was cost.

Mr. Chairman, what all of these statistics are telling us is that Congress and the Administration must focus their efforts on small business access to **affordable** health care in order to effectively reduce the number of uninsured in our nation.

The National Association for the Self-Employed strongly believe that Association Health Plans (AHPs) and health care tax incentives including tax deductions and tax credits for the self-employed are necessary to provide affordable health coverage.

Associations Health Plans (AHPs)

There are approximately 135,000 associations in existence today within the United Sates representing nearly every industry, profession, cause and interest. Nine (9) out of ten (10) adult Americans belong to an association and one (1) in four (4) belong to several associations.

Associations offer people the opportunity to come together with others that have similar vocations and interests. Many also bring tangible value to their members through member benefits. For example, we at the National Association for the Self-Employed offer over 100 benefits to our membership, which range from tax and business advice to discounts on business products and services. What provides us the ability to offer these opportunities to our members is economies of scale. By pooling the purchasing power of our over 200,000 members and we can work with vendors to offer discounted products and services to our membership. The NASE can also tailor benefits specifically to our membership needs. Small businesses with five (5) employees or under have very different needs from small businesses with 25, 100 or 250 employees. The self-employed and small business community should also be able to pool their purchasing power in the acquisition of health coverage and Association Health Plans are a method to do just that.

On average, a worker in a firm with less than 10 employees pays 18% more for health insurance than a worker in a firm with 200 or more employees. Disturbingly, health insurance premiums for small businesses are again increasing at double-digit rates, while at the same time benefits and health plan choices are decreasing. AHPs can help remedy the severe lack of access to affordable health insurance for small businesses.

AHPs can reduce health insurance costs by 15% - 30% by allowing small businesses to join together to obtain the same economies of scale, purchasing clout, and administrative efficiencies now available to employees in large employer and union health plans. New coverage options for the self-

employed and small business workers will promote greater competition and choice in health insurance markets. Tough new solvency standards protect patients' rights and ensure benefits are paid.

Employee enticement and retention within the small business community are also an indirect positive affect of Association Health Plans. By making health coverage affordable to small employers, AHPs will assist small businesses in competing with larger employers with extensive benefit packages in acquiring and retaining qualified employees.

Currently in the House of Representatives, Representatives Ernest Fletcher and Cal Dooley have sponsored the Small Business Health Fairness Act (H.R. 1774, S. 858, Hutchinson), which provides for expansion of Association Health Plans. We support this legislation. Also, the House version of the Patient's Bill of Rights includes an amendment that allows for creation and expansion of AHPs and MSAs and will hopefully survive conference with the Senate. Association Health Plans will empower small business entrepreneurs with the same tools, which large employers use to make health coverage affordable for working families.

Dispelling the Myths Behind Association Health Plans

Many arguments have arisen against Association Health Plans (AHPs) and the affect they will have on the uninsured. One such argument is that the existence of AHPs would eventually increase premiums for other employer and state sponsored plans. The assumption is that AHPs would offer less comprehensive health coverage at a very low cost due to their exemption

from state mandates. A lower costing health plan with minimal coverage would attract only the healthier small employers and employees and thus leaving the state-regulated market with only high-risk, high-cost individuals. The large problem with this argument is that it is simply based on assumptions.

Firstly, adverse selection is already illegal under HIPAA, which states that all group health plans may not deny or condition coverage on health status.

Secondly, AHP legislation contains provisions to further protect against any possibility of adverse selection. AHPs must actively market to, and accept, all member employers regardless of the claims history or health status of their employees. AHPs are prohibited from excluding or charging higher premiums for sick employees, and are restricted from setting their premiums in a way that might force higher claims companies to pay higher premiums than other similarly situated employers in the plan. Thus, AHPs cannot force a high claims employer out of the plan.

Thirdly, only bona fide associations, which are formed for purposes other than providing health insurance for at least three years, can qualify to offer an AHP. Thus, AHPs cannot be formed to "cherry pick" only the good risks from the health insurance market. An expansion of AHPs will actually strengthen health insurance markets and reduce adverse selection by providing affordable coverage to many uninsured workers. Adverse selection already exists when low risk individuals (primarily younger, healthy people) forego purchasing coverage because they deem it too expensive and thus stay outside of state insurance pools.

And finally, the assumption that associations, which are exempt from state benefit mandates, would, for some reason, offer less comprehensive health insurance, is unfounded. We can see that current self-insured, self-funded plans, which are also exempt from state mandates, do not offer less complete and poor quality insurance.

Another oppositional argument is that AHPs would not significantly reduce the administrative costs associated with health plans. The CBO stated that it found "...no substantial evidence that joining a purchasing cooperative produced lower insurance costs for firms." However the Associated Builders and Contractors plan, which operates nationally, had total expenses of 13 ½ cents (13.5%) for every dollar of premium in 1999. These costs include all marketing, administration, insurance company risk, claim payment expenses and state premium taxes. Alternatively, small employers who purchase coverage directly from an insurance company can experience total expenses of 30 cents (30%) for every dollar of premium or more. According to the October 2001 GAO Report, "20 to 25 percent of small employers' premiums typically go toward expenses other than benefits, compared with about 10 percent for large employers. These administrative expenses increase the per-person cost of insurance more for smaller groups than for larger groups because there are fewer people to share the cost." It stands to reason that small businesses that purchase coverage through an association health plan can expect to save 15 to 20 percent, or more.

Tax Policy and Health Care

Tax credits and deductions are also a viable solution to begin addressing the existing insurance inequities in the tax code. A new idea in tax policy is to create parity between employer provided health insurance and health insurance for the self-employed.

Currently, premiums for an employer who sponsors health coverage for his/her employees are not subject to FICA withholding tax (Social Security and Medicare). Employees that utilize an employer sponsored health plan are also not subject to FICA withholding tax (Social Security and Medicare) and thus enjoy health insurance premiums free from income tax and FICA tax. However, self-employed individuals are subject to the self-employment tax (Social Security and Medicare) on health insurance premiums for themselves and their dependents. The result is that the self-employed pay a tax premium on health insurance of up to 15.3% of the cost of that insurance.

To explain this further here is an example:

John works for Widget Company, a small business with only two employees, including the owner. Widget Company provides employer paid health insurance for it's two employees and their dependents. Widget Company appropriately deducts in total, the cost of the employee health insurance on its business tax return as an "ordinary and necessary" business expense as authorized by the Internal Revenue Code. Further, none of the health insurance premiums are included in the employee's W-2 income and

are therefore free from Federal income tax and FICA withholding tax (Social Security and Medicare). The preferential tax treatment of the health insurance premiums provides a significant tax benefit Widget Company and for employee John. Since John does not include the value of the premiums anywhere in his taxable income, he has received a tax benefit of up to 35% of the insurance cost. Note that Widget Company has not paid any income tax or FICA tax on the premiums either.

John leaves Widget Company and becomes self-employed doing the same types of business processes he did for Widget. The cost of health insurance premiums are not deductible as an "ordinary and necessary" business expense and are therefore subject to Federal income tax and self-employment tax (Social Security and Medicare). The health insurance premiums may qualify for a limited deduction from gross income as a "self-employed health insurance deduction" on page 1 of John's individual income tax return (Form 1040). Even if John can utilize the income tax deduction for 70% of the premiums, he must still pay income tax on 30% of the premiums. In addition, John must pay self-employment tax (Social Security and Medicare) on 100% of the premiums. In total John has a tax detriment for purchasing health insurance of up to 25% of the premium cost.

This process is another example of the current inequities in the tax code that are detrimental to the self-employed. By allowing the self-employed to claim their health care premiums as a business expense the net cost health insurance premiums will be reduced by up to 25%, which is a significant reduction. Note that allowing premiums to be an "ordinary" business expense would not affect current income tax deductions after 2002.

Acceleration of 100% deductibility of health insurance for the self-employed is another important tax deduction that would greatly assist the self-employed community. Currently it will be phased in by 2003. However, the NASE feels that sooner is better than later. We would like to see 100% deductibility available in years beginning after 2001.

Finally, a tax incentive such as a refundable tax credit should be made available for the purchase of health insurance coverage for all individuals. It would cover 100% of the cost of health insurance coverage for up to $500 for individuals and $1,000 for families. The refundable tax credit should be made available to those individuals whose employer does not sponsor or contribute to an individual or family health plan for their employees and for the unemployed. Self-employed individuals would have the opportunity to utilize either the self-employed health insurance deduction or the refundable tax credit but not both.

Conclusion

We here in Washington D.C. discuss issues through facts, figures and legislative solutions. But there is also a personal face to the current health care issues that plague the self-employed and small business community. Recently, NASE Member, Lance Kisby, a Pediatric Dentist in Needham, Massachusetts had contacted the NASE office to tell his story on how the high costs of health care are affecting his small business. Dr. Kisby informed the NASE that in 2000 the cost of his health insurance premiums went up approximately 7%. In May of 2001, he received a notice that his premiums would be rising by approximately 30%. By September 2001, he received a second notice that in January of 2002 he would have yet another

premium increase. Dr. Kisby maintains that these increases will cost him $6,000 more this year. These increases have forced him to pass along some of the cost to his patients by raising his fees 5% and to work longer more hours to cover the loss of profit due to the higher health care costs. Dr. Kisby remarks, "As a self-employed person, I recognize that there are so many hours in a week and that I can only raise my fees so much and still be competitive while also having money to feed my family."

Dr. Kisby's story characterizes the plight the self-employed face in attempting to acquire and provide affordable health coverage for themselves and their employees. Association Health Plans (AHPs) and health care tax incentives would go a long way to solve not only the problem of small business access to affordable health care but to also alleviate the growing ranks of the uninsured.

House Committee on Small Business

Small Business Access to Health Care

Testimony of
Richard E. Curtis
Institute for Health Policy Solutions

February 6, 2002
Room 2360, Rayburn House Office Building
Washington, DC

Mr. Chairman and members of the committee, I am Richard E. Curtis, President of the Institute for Health Policy Solutions, a not-for-profit, non-partisan education and research organization that does not advocate specific legislation. The Institute was established to objectively analyze and develop approaches to solve health system problems, and brings special expertise and interest to policy approaches that complement or harness private sector roles. Much of the Institute's work has been focused on coverage of uninsured working families, and on approaches to provide coverage through uninsured small firms. This work has included analysis and technical assistance with respect to purchasing pools which extend choice of competing health plans to small firm workers.

This committee has long recognized and pursued the potential economic advantages of pooled purchasing for small employers, and many members strongly support the consumer choice of competing plans (and associated provider choice and continuity of care) promised by individual tax credits. Consumer-choice health purchasing groups for small firms are an effort to blend these attributes. Without the availability of subsidies, and in the face of understandable (related) health plan resistance, there have only been a few relatively small successful private employer organizations of this type. But it is worth noting that the retention rate, i.e., the proportion of participating small employers who renew coverage through these pools, is far higher than in the conventional small-employer market. Further, in the face of the economic downturn and rapidly rising small employer premiums, current enrollment growth (e.g., in employer purchasing groups in California, Connecticut and New York City) suggests that the power of choice is particularly attractive when the conventional market's shortcomings are most apparent.

As you know, a disproportionate share of uninsured workers are employed by small businesses. About 35% of uninsured workers aged 18-64 are employed by a firm with fewer than 25 workers, while fewer than 20% of all workers are employed by such small firms.

But it is also important to note that more small-firms workers have coverage through their own employer (9.3 million) than are uninsured (8 million). And many more (6.5 million) have other employment-based coverage as a dependent—typically through their spouse's employer—than have individual coverage (2.1 million). (Fronstin, 2001. Data are for 2000, drawn from EBRI tabulations of the March 2001 CPS supplement).

As Congress considers approaches to reach uninsured workers and their families, for a variety of reasons it seems sensible to develop approaches that largely complement rather than largely replace existing coverage through small firms.

Surveys indicate that working families generally prefer employment-based coverage to coverage through the individual market or government. (Duchon *et al.* 2000) However, proposals for individual tax credits and for SCHIP- or Medicaid-based coverage are sensible for many workers and dependents who are not, and are not likely to be, effectively covered through traditional employment based coverage. For example, those without stable or full-time employment could be well served by subsidy alternatives that allow affordable, stable coverage and consumer choice of health plans. The administration's emerging proposal for tax credits and related state or private purchasing pool programs seems to afford the opportunity and latitude to develop such alternatives, especially for the low-income uninsured.

However, it would be sensible to consider some selected linkages for variations on small-employer-based coverage rather than imposing an absolute barrier between individual tax credits and employment-based coverage.

Specifically, a related population works for low wage "micro" employers who are often not in a position to spend the money or time necessary to purchase employment based coverage. While a minority do offer coverage, they often find it difficult to find a plan that meets their employees' varying needs and circumstances, and are much more likely than other small employers to drop coverage within a couple of years. But they do offer the advantages of job-based enrollment and automatic payroll deductions for premium contributions. Further, a number of these employers can afford a small contribution and could enhance worker stability and job satisfaction by offering a convenient and affordable job-based venue for health insurance. But it seems these benefits could be lost for employer groups with a majority of low-wage workers, where the proposed individual tax credits would be worth considerably more than existing tax exemptions for employment based coverage.

A relatively simple variation might be a sensible way to reach more uninsured workers and dependents, while also affording some benefit to their small employers who choose to participate. That is, allow small firms with a majority of low wage workers (e.g., firms with fewer than 20 workers, with a majority of qualifying workers who make less than $20,000 per year) to voluntarily contribute something towards such pool coverage, exempt such contributions from FICA (but not personal income) taxation, and allow their workers to apply individual tax credits towards their share. (Some states, for example, Connecticut, are developing similar targeted pilot programs that might use other available subsidy sources).

Background and Additional Information

The concept of individual choice of health plans through private markets has broad appeal. People want to be able to choose their own physicians and do not want to be forced to change physicians just because they have changed jobs. Even if provider selection were not an issue, people care about how they are treated and resent being forced to stay with an employer-selected plan that has treated them poorly. They want to be able to "vote with their feet." Many public-

employee and large-employer health benefit programs already offer workers choice among an array of participating health plans, and it seems likely more and more large employers will do so.

But, for a variety of reasons, very few small employers offer choice. As we seek to reduce the number of uninsured, it is important that workers and families be able to choose their own health plans. To some policy makers, this means giving people flexibility to buy health insurance wherever they want and can, which basically means either through the existing individual health insurance market or, for some, through a voluntary association they may belong to.

But the current voluntary, unsubsidized individual health insurance market is generally dysfunctional. It is characterized by high turnover, high average medical costs and risk segmentation or risk selection, by both individuals and carriers, resulting in aggressive underwriting and competition among carriers largely based on risk selection. Because of these inter-related problems, individual insurance policies have high overhead costs, and premiums vary widely based on health status. Therefore, it becomes difficult to design a tax credit for individual coverage that will extend a cost-effective means of covering uninsured workers and their dependents.

Purchasing pools that offer workers choice among competing health plans offer a solution to many of these problems. They provide a workable venue for individual choice of health plan while maintaining the economies and grouping advantages of employment-based coverage.

Such pools have the administrative capability to combine contributions from multiple sources and forward them to the worker's chosen health plan. Pools now operating already do this with respect to employers' and workers' contributions from multiple employers. This capacity could readily be expanded to include public sources, whether tax credits or program funds such as SCHIP. That is, pools could efficiently channel/combine tax credits with other public subsidies available to family members and with the family's own contributions (and the employer's contribution, if any) to provide a single, stable source of ongoing coverage ("one-stop shopping") for entire working families. If whole families were covered under one plan, enrollment and service use would be easier, and children would be more likely to get needed care because they would be enrolled in the same health plans as their mothers.[1]

Under the Administration's emerging health-insurance tax-credit proposal, credits might be used to purchase coverage in the non-group (individual) insurance market, through private purchasing groups, or through state-sponsored insurance purchasing pools and state high-risk pools.

But it would be unfortunate if such pools could deal directly only with individuals, with no opportunity for uninsured small firms to participate. The vast majority of the uninsured are workers or dependents of workers (63% of the uninsured live in families headed by a full-time, full-year worker), and two-thirds of Americans already get their health coverage through a work-based plan. (Fronstin, 2001) Signing up for a health plan at work is how most workers and

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[1]Common sense suggests that parents will know better how to get care for their children if they are familiar with how the health plan works because they use it themselves. Available research documents that children are more likely to use care if their parents use care (Hanson 1998).

families get their health coverage. Payroll deduction is the easiest and most reliable way for workers to pay their share of insurance premiums. Without it, individual families have to be billed periodically or agree to permit automatic deductions from their bank accounts to pay premiums. When they forget to pay, coverage can lapse, and reinstatement procedures consume administrative resources and raise costs.

- Moreover, Americans like getting their health coverage through their work. The Commonwealth Fund's 1999 National Survey of Workers' Health Insurance found that adults who had coverage through their employer greatly preferred that approach over buying insurance directly from insurance companies (56% vs. 20%). Even the currently uninsured preferred employer coverage to direct individual purchase (35% vs. 27%) (Duchon *et al.* 2000).

Thus, I believe it makes a great deal of sense for purchasing pools to work with otherwise uninsured small employers to offer a choice of health plans to workers. Even if (or, perhaps, especially if) an employer does not now offer health coverage, working with a purchasing pool could allow an employer the opportunity to offer his workers an easy way to use their newly available tax credits to choose a health plan for themselves and their families. All the employer has to do is distribute and collect enrollment forms provided by the purchasing pool, deduct the workers' share of the premiums from their paychecks, and write one monthly check to the purchasing pool in response to an itemized bill.

The pool can do the hard work of negotiating benefit plans and rates with multiple health plans, sorting out and transmitting premium payments correctly, and advocating on behalf of workers with the health plans when there is a problem. As part of their administrative responsibilities, pools would develop and distribute consumer information materials (brochures, benefit plan summaries, combined provider directories, health plan comparative pieces, etc.), answer general information calls, handle member inquiries about applications, eligibility, billing, or payment; assist members with complaints about health plans; and establish procedures for resolving grievances, etc.

More formally, the basic purposes of a purchasing pool are:

- To offer its (individual) members a choice among competing health plans and alternative benefit packages (covered services and cost-sharing levels) more efficiently and effectively than alternative approaches;
- To provide the administrative systems necessary to enroll members in their chosen health plan, and to collect and transmit premium contributions made by or on behalf of members to their chosen health plans as simply and efficiently as possible;
- To assure its members that participating health plans offer good value, and to serve as an ombudsman when a member requests assistance in resolving a problem with a plan; and
- To offer small employers a single, simple mechanism for giving their workers access to a choice of health plans through payroll deduction. (The pool provides employers with a single point of contact for health insurance matters, including a single consolidated bill and single enrollment form covering all participating health plans.)

As the Administration's proposal recognizes, subsidies, whether in the form of vouchers or tax credits, must be available on a current basis, when premiums are due, if they are to help low-income people buy health insurance. After-the-fact reimbursement or once-per-year tax refunds will not be effective. Therefore, the Administration's proposal makes provision for "advance payment" of tax credits, and it would seem pools could play a key role in that process. Similarly, pools would have all the information necessary to provide verification to the IRS that individual tax credit recipients were in fact enrolled.

In summary, private purchasing pools can:

- Make more cost-effective health insurance options available to low-wage small businesses and their workers, allowing workers to choose among several competing insurance carriers; and
- Creating an infrastructure to efficiently utilize federal and state subsidy funds to reduce premium costs for low- or modest-wage workers of uninsured or predominantly low-wage firms.

Further thought should be given to how the Administration's proposed tax credits might be creatively harnessed to encourage more small employers, especially the smallest firms with primarily low-wage workers, to arrange coverage for their workers through purchasing pools.

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Testimony for

THE UNITED STATES HOUSE OF REPRESENTATIVES

SMALL BUSINESS COMMITTEE

February 6, 2002

By

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Good morning. My name is Janet Trautwein. I am the Director of Federal Policy Analysis for the National Association of Health Underwriters. **The National Association of Health Underwriters** is an association of insurance professionals involved in the sale and service of health insurance, long-term care insurance, and related products, serving the insurance needs of over 100 million Americans. We have almost 18,000 members around the country. NAHU has been a proponent of refundable health insurance tax credits to address the problem of the uninsured for more than a decade, and is pleased to have this opportunity to discuss the practical application of a tax credit with the members of this committee. We believe a refundable health insurance tax credit is an important component of an overall program to increase health care access for small business owners and their employees and will provide a real solution to the problem of the uninsured in America by addressing affordability -- the most basic component of access to health care.

The current estimate on the number of uninsured in this country is approximately 40 million people. That number represents an increase from a few years ago, despite numerous state and federal efforts to improve access. Over half of the 40 million uninsured Americans are the working poor or near poor, many of whom already have access to health insurance through an employer-sponsored plan. Since employers already provide access to health plans and pay a significant portion of the premiums for many Americans, why do we have so many uninsured? The problem isn't access – it's affordability. **They just can't pay for it.**

This inability to pay has many causes. As we know, the United States government gives a tax break to people covered under their employer's health insurance plan. Health insurance premiums paid by an employer are not taxable as income to employees, even though many people consider employer-paid health insurance to be a part of compensation. Although this tax break has provided an excellent incentive for many people to become insured, it has also inadvertently created another problem – lack of tax equity. When an employer pays $100 in tax-free health insurance premiums for an employee in a 30% tax bracket, it's worth $30 to that employee. To another employee in a 15% tax bracket, it would be worth $15, and for the low-income employee with no tax liability or the person who is self-employed or otherwise has no employer-sponsored plan available, the tax break is worth nothing. That's why many low-

income employees who must pay part of the cost of employer-sponsored health insurance coverage for themselves or their family have declined coverage. Many of these employees work for small businesses. Most people in employer plans benefit from both the dollar amount of the employer contribution and the tax exemption on employer-sponsored health insurance premiums. Low-income individuals only benefit from the employer's contribution if they are able to pay their share of the remaining premium, and they don't benefit at all from the tax exemption. Increased deductibility of health plan premiums for the self-employed has helped and will help more as greater deductibility is phased in. Unfortunately, however, deductibility does nothing for the bulk of the uninsured – the working poor with no or very low tax liability.

People with no tax liability don't benefit from a deduction for two reasons. First, if they owe no taxes, there is nothing from which to deduct their premiums, even if the deduction was available without the requirement that a person itemize. Second, and probably more important for the working poor, a deduction or even a credit that is only available at the end of the year is of no value to them because they need the funds at the time their health insurance premium is due. They can't wait a year to be reimbursed, so they forego insurance entirely. That's why they are uninsured now.

Fortunately, there is a solution for this problem. A refundable, advanceable tax credit would allow individuals to receive their tax credit dollars monthly, when their premiums are due. This type of credit, advanced monthly and administered through the insurance company or the employer, provides the following benefits:

- It is simple to understand.
- It is almost impossible to abuse, since the insurance company or employer would certify that coverage was purchased.
- It enhances the effectiveness of COBRA's access mechanism by providing a means to pay COBRA or other health insurance premiums when people change jobs.
- It provides early retirees with needed dollars to help them purchase a health insurance policy.
- Small employers who currently can't afford to provide a health insurance plan would,

with the combination of the contribution they could provide and dollars provided to eligible employees through a health insurance tax credit, be more likely to offer a group health plan to workers.[1]

Tax Credits in Employer-Sponsored Plans

Some health insurance tax credit proposals do not allow individuals to use a tax credit in an employer-sponsored plan. A better solution is a health insurance tax credit designed to be used either to buy coverage in the individual health insurance market or to help an employee pay his or her share of premiums in an employer-sponsored plan. Most people are happy with the employer-based system, according to a 1999 survey by the Employee Benefits Research Institute, and many uninsured individuals already have high-quality employer-based coverage available to them. A recent NAHU survey of small employers shows that many small employers pay most or all of an employee's health insurance premium, but little or none of the cost of coverage for dependents. Allowing low-income employees to supplement their employer's contributions with a refundable tax credit would allow families to be insured together, which many employees prefer, and would provide the funds necessary to allow them to come up with "their share" of health insurance premiums. It would also address concerns from the business community, such as declining participation in their plans, and would empower individuals to select their own place of purchase, rather than having it imposed on them by the government.

Should a Tax Credit Be Flat or a Percentage of Premiums?

Some people claim that because the cost of individual health insurance is different for individuals of different ages and in different states, a flat credit is unfair and inflexible. It is true that health insurance costs are different for different populations. But a credit based on a percentage of premiums is difficult to administer because of these very differences. It is very important that a health insurance tax credit be advanced monthly, when premiums are due. This can be done through insurance carriers for those who purchase individual health insurance coverage as well as through the employer payroll process for those who purchase coverage in an

[1] See NAHU survey of small employers, March 2001.

employer-sponsored plan. If administration becomes too difficult, it won't be cost-effective for employers and insurers to handle this administration, and they will elect not to advance tax credits to individuals. This will result in the tax credit not being available to individuals and families until they file their tax return.

How Much Should the Tax Credit Be?

Over the years, NAHU has spent a considerable amount of time looking at the dollar amount of a health insurance tax credit. In doing so, we looked carefully at the amount of coverage that is currently financed by employers. Employers pay for much of the coverage that insures most people today. It is very important that in our zeal to do something about those without health insurance that we don't inadvertently discourage employer funding of coverage for those who are already insured today. For that reason, it is important that a health insurance tax credit be low enough so that it will not provide an incentive for employers to discontinue their financial contributions towards plans. At the same time, it is important that the credit be large enough to provide a meaningful incentive for people without access to an employer-sponsored plan to obtain coverage.

A credit in the range of $1,000 for individuals and $2,000-$2,500 for families is not large enough to cause an employer to stop providing coverage for employees, yet still provides a good base to finance coverage, even for employees purchasing coverage in the individual health insurance market. Keep in mind that, if it is available, coverage offered in employer-sponsored plans provides a significantly higher level of benefits in many cases than what is available in the individual market, in addition to being less expensive. The controlled access in employer plans is much more effective at keeping a balanced risk pool than the individual health insurance market. But a tax credit would bring new people into the individual health insurance pool and would over time encourage insurance companies to write individual health insurance policies geared to the size of the credit, offering more options and making it possible for low-income families to obtain coverage without paying much more than the credits available.

Is a $1,000 Tax Credit ($2,000 for a Family) Large Enough to Buy Reasonable Coverage?

Individuals without employer-sponsored health insurance currently must purchase coverage in the individual health insurance market entirely on their own. This is particularly hard for low-income employees, who may have to choose between health insurance and groceries. Even employees who have employer-sponsored coverage available may not be able to participate because they can't afford their share of the premiums. A health tax credit should be considered a base from which to build on the financing of health insurance coverage. It is not designed to take away the role of the employer in the financing of health insurance coverage, or to replace personal responsibility.[2]

What if Someone Doesn't Qualify for Coverage in the Individual Health Insurance Market due to a Health Condition?

In most states individual health insurance requires that a person be in relatively good health. If a person does not qualify for coverage based on his or her medical history, many states have a high-risk pool or some other mechanism to ensure that coverage is available. High-risk pools provide an affordable alternative for high-risk individuals who don't have access to employer-sponsored coverage and must purchase individual health insurance coverage. A refundable health insurance tax credit could help eligible high-risk individuals afford the cost of health insurance coverage in high-risk pools in the same way it would be used for others who purchase coverage through their employer's plan or through the regular individual health insurance market. In addition, states without any safety net for the medically uninsurable should be encouraged and provided with incentives to develop programs to ensure that coverage is available for these individuals.

Administering a Refundable Health Insurance Tax Credit

The Treasury Department would have primary responsibility for administering tax credit payments. The credit, while owned by the individual, would not be paid directly to the

[2] To get an idea what is available in the individual health insurance market, see "Individual Health Insurance Coverage options across the United States," March 2001, National Association of Health Underwriters.

individual, but would be transmitted to an insurance company, employer, high-risk pool, or other organization maintaining the individual's insurance account. The credit could be used only for the payment of private insurance premiums, and could not exceed the total cost of the premiums. Only health plans eligible as creditable coverage under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) would be eligible for credit payment. The credit would be available on a monthly, prorated basis, in order to ensure the continuing availability of credit funds throughout the year, particularly in cases of job change, and to help protect against fraud.

In cases of employer-provided insurance, the monthly tax credit allocation can be handled as part of the regular withholding process. The credit would be shown as a specific line item on the pay stub. Federal income taxes withheld by the employer on behalf of employees would be reduced by the amount of the credit before being sent to the government.

For those individuals purchasing coverage in the individual health insurance market, the monthly tax credit allocation could be subtracted from the regular monthly health insurance premium due, with the insurance company using normal billing mechanisms for the balance, if any, of the premium. As with employer plans, insurance companies could reduce federal taxes owed by the amount of credits they had advanced to eligible individuals.

Economic Impact of a Health Insurance Tax Credit

A refundable health insurance tax credit for low-income individuals is an innovative way to achieve affordable health insurance coverage through the competitive private sector. A health insurance tax credit will help ensure that low-income Americans who have the greatest difficulty affording coverage will have a basic level of resources to purchase health insurance. The tax credit, by being available only for the purchase of private sector insurance, will allow a shift of low-income individuals from the very costly Medicaid program into private insurance plans. A health insurance tax credit would also help to lower the per capita cost of insurance, by reducing the amount of uncompensated care that is currently offset through cost shifting by health care providers to private sector insurance plans, and by substantially increasing the insurance base, spreading the cost over a wider number of people.

Summary

A refundable health insurance tax credit represents a simple and realistic way to extend private health insurance coverage to those uninsured individuals and families who are most in need of assistance. It is fair and is easy to administer. It is a private-sector solution to a difficult public problem. It gives people the tools to make their own decisions.

The most important patient protection is the ability to afford health insurance coverage. Real access to health care and choice can't exist without the dollars required to buy a health plan.

I appreciate this opportunity to testify today and would be happy to answer any questions the committee may have.

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TESTIMONY

Before the

THE COMMITTEE ON SMALL BUSINESS
U.S. HOUSE OF REPRESENTATIVES

on

SMALL BUSINESS ACCESS TO HEALTH INSURANCE

Presented by:

MARY NELL LEHNHARD
SENIOR VICE PRESIDENT
POLICY AND REPRESENTATION

February 6, 2002

Mr. Chairman, I am Mary Nell Lehnhard, Senior Vice President of the Blue Cross and Blue Shield Association (BCBSA). I am pleased to present the views of the nation's 43 independent Blue Cross and Blue Shield Plans on expanding health coverage among employees of small businesses.

Collectively, Blue Cross and Blue Shield Plans are the nation's largest provider of insurance coverage to small employers. One-in-four small firms that offer health care coverage to their workers purchase their coverage from Blue Cross and Blue Shield Plans.

BCBSA recognizes the challenges faced by small firms in offering insurance to their employees. Blue Cross and Blue Shield Plans have been leaders in developing innovative health plans for small employers, including low-cost plans and special products for low-income workers. Blue Cross and Blue Shield Plans also led the way in working with state officials to assure access for small employers through enacting laws that assured large insurance pools of small employers that would maximize efficiencies and cross-subsidies.

BCBSA has advocated for tax reforms to make coverage more affordable for small firms and individuals. One innovative component of our proposal, as I will discuss, is a tax credit that focuses on the high rates of uninsured among low-wage firms.

We are pleased that Congress is studying ways to address the uninsured problem. Any workable solution for the uninsured, however, **must build on a stable health insurance market**. We are concerned that legislation exempting Association Health Plans (AHPs) from state laws would

undermine state insurance reforms, ultimately destabilizing the insurance market and jeopardizing state and federal efforts to expand coverage for small firms and individuals. The net result of this AHP legislation would be higher premiums for the majority of small firms and a return to a small group insurance market driven by adverse selection.

In my remarks, I will make five points:

I. States have enacted legislation requiring insurers to create large pools of small employers in order to address access and affordability;

II. Association Health Plan (AHP) legislation would lead to smaller employer pools and reinvent problems recently addressed by the states;

III. Exempting AHPs from state reforms is not the solution to the problem of access for small firms – many of the purported benefits of this legislation have been overstated;

IV. Exempting AHPs from state reforms raises larger public policy issues; and

V. Congress should focus on tax-based solutions for small firms and the uninsured, such as the proposal released by BCBSA.

I. States Have Enacted Legislation Requiring Insurers To Create Large Pools Of Small Employers In Order To Address Access And Affordability

The Problem:

In the 1980s, small employers faced serious problems trying to obtain and retain health coverage. In some cases, health coverage was simply unavailable for businesses with less healthy workers at affordable rates. Small firms confronted three major obstacles to providing health coverage:

- ***Extreme variations in rates:*** Small businesses were faced with an insurance market where rates could be extremely low for healthy groups, but very high for groups with sick

employees or dependents. Small firms routinely experienced steep premium increases if one of their employees became sick, forcing them to drop coverage for all of their workers. During this period, an employer with less healthy workers could face premiums that were 10 times those of employers with very healthy workers. Insurers had many "pools" of employers, which resulted in fragmentation and meant that no meaningful cross-subsidies were provided.

- ***Lack of availability:*** Many small firms discovered that insurers refused to offer coverage if they had sick employees -- aggressive screening for existing medical problems was common. For these firms, coverage was not accessible even if they could afford to purchase it.

- ***Vulnerability to being dropped:*** Small employers who were able to buy coverage often found that their coverage was not renewed if their employees had filed high cost claims during the previous year. These employers were fortunate if they found another insurer willing to cover them; some were forced to go without coverage.

State officials recognized these problems and identified their root cause: a small employer health insurance market with competition based almost entirely on aggressive risk selection. When health care costs rose during the late 1980s, small employers with healthier employees began to resist the idea of subsidizing the cost of other small employers who had sick employees. They wanted their premiums to reflect only the costs of their own workers.

At the same time, many insurers realized that they could be much more competitive -- that is, offer lower initial premiums -- by screening applicants to select only the groups with healthier people than through techniques to manage health care costs. As a result, most insurers rated

groups aggressively and according to the health status of each group's employees. For small employers with healthy workers, premiums dropped. But for other small employers with less healthy workers, this "risk-selection" meant much higher premiums.

Response by the States:

In the late 1980s, states began responding to the problems faced by small firms by enacting reforms to make small group health coverage more accessible and affordable.

To address wide variations in premiums charged to particular groups based on health status, all states adopted risk-spreading requirements that assured cross-subsidization between low- and high-cost groups. These rules set limits on what an insurer could charge its sickest group compared to its healthiest group (both within a single product and across all products offered by the insurer). Insurers are now forced to pool all their business; this assures cross-subsidies and prevents insurers from pricing their products in a manner that avoided high cost small employers.

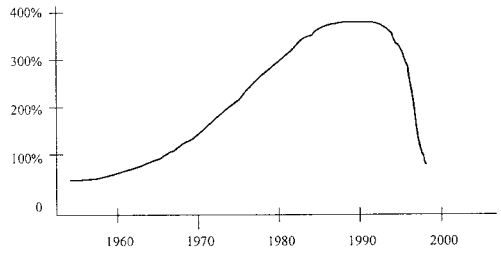
States said: "The small group market needs to be reformed in order to function like a true insurance market." This meant ensuring meaningful cross-subsidies. These cross-subsidies made health coverage more affordable for small businesses that had employees with serious medical conditions. Small businesses with healthy employees -- which would pay more initially -- would benefit when their employees required health care.

Insurers in all states must also abide by numerous other requirements. These include laws that require insurers to accept all small employers regardless of the health risk of their employees,

place limits on the use of pre-existing condition exclusions, and prevent insurers from canceling coverage for any small employer.

These reforms successfully reversed aggressive competition based on risk selection, which was creating wide variations in premiums and left the sick without health coverage, by creating broad insurance pools for small employers (Figure 1). As you can see in this figure, rates typically charged to less healthy small groups (relative to rates for low-cost small groups) declined significantly after the passage of state small group reforms. These laws benefit all small employers because today's healthy group may be tomorrow's sick group.

Figure 1: Typical Maximum Variations in Rates for Small Group Health Insurance due to Demographic, Durational, Experience, and Underwriting Adjustments used by Insurers



Notes:

- In the 1960s, small group rates were Community Rated, or Community Rated with Demographic Adjustments.
- The use of Durational Rating, Experience Rating, and Large Underwriting Adjustments appeared in the 1970s, grew in momentum, and reached their peak in the late 1980s.
- The adoption of the NAIC rating model laws in the early 1990s reversed the trend.

Source: Timothy Harrington, Actuary, W.M. Mercer, Inc., 1999

Studies by researchers from the Urban Institute have found that comprehensive state small group reform laws have not led to a decline in coverage, as some proponents of AHP legislation contend. Rather, this research indicates that state small group reforms stabilized the market and prevented further erosion of coverage (Zuckerman & Rajan, 1999).

II. AHP Legislation Would Lead to Smaller Employer Pools and Reinvent Problems Recently Addressed by the States

As Congress moves forward regarding access issues for employees of small employers, BCBSA urges you not to enact legislation that would undermine the progress that has already been made by the states. We recognize the good intentions behind the proposed AHP legislation -- expanded coverage for small employers. However, we believe this legislation would take us back to aggressive competition based on risk selection; it would let association health plans out from under the very state reforms designed to put an end to the practice of risk selection.

This legislation would not increase the accessibility and affordability of health insurance coverage. Instead, it would lead to:

1) ***Unaffordable premiums for many small firms:*** Exempting AHPs – including certain multiple employer welfare arrangements (MEWAs) -- from state law would undermine state risk spreading laws and increase premiums by creating opportunities for AHPs to select a population that is healthier than those in the state-regulated pools.

Under current proposals there would be a number of opportunities for AHPs to risk select. For example, they could:

- avoid attracting less healthy groups by not covering the state-mandated benefits that less healthy people find desirable or by setting low lifetime limits;
- establish membership criteria that would essentially limit enrollees to healthier groups (rather than taking any small group that applies, as required by HIPAA);
- market association membership only in areas of the state with lower health costs and a younger, healthier population; or
- set rates based only on the claims experience of their group (i.e., they could avoid requirements to cross-subsidize less healthy groups that do not join the association).

By exempting AHPs from state law, the state-regulated market would be left with high-risk, high-cost individuals. Premiums in the state pools would then increase, triggering a spiral whereby other healthier groups leave the state pool, generating another round of premium increases. States would not be able to stabilize these escalating rates because a large portion of individuals would be outside of their authority.

In 2000, the Congressional Budget Office (CBO) analyzed the association health plan legislation and concluded that AHPs would make coverage less affordable for the majority of small businesses while doing little to address the problem of the uninsured. The key findings of the CBO report are as follows:

- **Four in five workers would be worse off under AHPs:** According to the report, 20 million employees and dependents of small employers would experience a premium increase under AHP legislation, while only 4.6 million would see a rate reduction. In other words, the average small business would see its health insurance premiums rise under AHP legislation, not fall as proponents have claimed.

- **AHPs would save money primarily by "cherry picking":** The CBO estimated that nearly two-thirds of the cost savings for AHPs would result from attracting healthier members from the existing insurance pool, thereby increasing costs for those who remain in the non-AHP market. The report states that, "In the long run, one would expect the most successful AHPs to be sponsored by associations whose members had lower-than-average health care costs." Moreover, the CBO estimated that 10,000 of the sickest individuals would lose coverage under AHP legislation.

- **AHPs would eliminate benefits to cut costs:** Contrary to proponents' claims that AHPs could offer generous benefits (e.g., comparable to those offered by Fortune 500 firms) while lowering insurance costs, the CBO found that dropping state mandated benefits would be the second major method that AHPs would use to reduce costs (after cherry picking). The CBO estimated that one-third of costs savings in AHPs would come from eliminating state-mandated benefits.

- **AHPs would not reduce overhead costs:** Contrary to claims that AHPs could reduce overhead by 30 percent, "...CBO assumed that cost savings arising from the group purchasing feature of AHPs and HealthMarts would be negligible." The CBO found

"...no substantial evidence that joining a purchasing cooperative produced lower insurance costs for firms." Indeed, an analysis by William M. Mercer, Inc., found that AHPs would actually increase administrative costs for small firms by 1.5% to 5% of premiums, when additional costs such as royalties paid to the sponsoring association and membership dues were taken into account.

- **States with aggressive insurance reforms would see the most damage:** The report indicates that states with strict insurance reforms would be most attractive to AHPs. The report concludes that "in states with more tightly compressed premiums – where the most cross-subsidization occurs – low-cost firms would face the greatest potential difference in price between traditional and AHP/HealthMart plans." In states such as Massachusetts, New Jersey, and New York, which have strict limits on the rating factors that insurers may use in setting premiums for small employers, the effect on premiums in the state-regulated small group market could be significantly worse than CBO's average estimates.

While the results of CBO's analysis are compelling, other studies have found that AHPs could have even more dire consequences. The results of an Urban Institute study indicate that AHP legislation would actually reduce overall health insurance coverage. The results of the study, which were outlined in testimony by Len Nichols, Ph.D. before the House Commerce Health Subcommittee, indicate that net small employer coverage would decline by one percent under AHP legislation – in other words, the ranks of the uninsured would swell by about 250,000 individuals.

2) Reduced funding for state access programs: A majority of states have created high-risk pools to provide affordable coverage in the individual market for those with existing medical conditions. These risk pools are primarily funded by assessments on health insurance premiums. Under the AHP exemption proposal, only certain AHPs would be required to contribute to these pools or other state programs; any self-funded AHP in existence before the passage of this legislation would be exempt from paying state premium taxes. As a result, state assessments on insured small groups would have to increase in order to compensate for non-contributing AHPs.

3) Unpaid medical bills for consumers and providers through insolvency: Exempting AHPs from state law could leave consumers and providers with large unpaid medical bills. MEWAs -- a type of AHP -- have a history of bankruptcy problems. Failures of these health plans left thousands of unsuspecting consumers and businesses with millions of dollars in unpaid medical bills, according to a 1991 General Accounting Office report.

Unfortunately, the proposed solvency standards for self-funded AHPs remain inadequate. The solvency standards are undermined by inadequate liquidity standards and the allowance of stop-loss coverage to substitute for reserves. Also, the $5,000 assessment on AHPs for the federal insolvency fund provides inadequate up-front funding to protect against AHP failures.

The National Association of Insurance Commissioners, representing the state officials who work to assure health plan solvency, has testified that the solvency standards and regulatory framework of current AHP proposal remains inadequate to protect consumers. BCBSA is particularly concerned that existing solvency oversight by state insurance regulators would be

replaced by self-reporting that relies on the judgement and certification of paid consultants retained by the association.

4) ***Fraudulent schemes that victimize consumers.*** In an analysis of the association health plan legislation, Eleanor Hill, former Inspector General for the Department of Defense and Chief Counsel of the Senate Permanent Subcommittee on Investigations during its hearings on MEWAs, concluded that exempting AHPs from state insurance standards and consumer protections would put small employers, workers and their families at risk of fraud and abuse.

According to Ms. Hill, "...AHPs are fundamentally the same types of organizations as many MEWAs that have, in the past, been sponsored through associations. If exempted from state regulation, AHPs would pose the same kinds of unacceptable risks to consumers that were highlighted during the previous House and Senate Congressional hearings."

Congressional hearing testimony related stories of individuals who lost their homes, their credit, and sometimes lifesaving treatment because MEWAs had not paid their claims. Problem plans included some offered through builders associations, bar associations, religious associations, and small business associations. Many of those plans could qualify as AHPs under proposed association health plan legislation. "The mere presence of bona-fide associations as sponsors does not prevent consumer victimization."

The report concludes that, "Rather than expand access to affordable but also dependable insurance coverage, history suggests that the provisions, as written, would instead generate greater opportunities for fraud and abuse to again flourish at the expense of the public."

Moreover, transferring regulatory authority from the states -- which have tightened solvency standards -- to the federal government would place the responsibility for ensuring AHP solvency on an unprepared Department of Labor (DoL). It would also make the federal government liable for unpaid benefits in the event of insolvency.

5) Creation of a large, unresponsive regulatory infrastructure. AHPs would operate as federally certified insurance companies that market coverage to small firms and individuals. As such, the federal government would need to reproduce regulatory processes and functions already performed by state insurance regulators, such as:

- Licensing/certification of health plans;
- Monitoring market conduct (e.g., preventing deceptive marketing practices);
- Assuring that rates are reasonable in relationship to benefits offered;
- Performing financial examinations to assure that plans remain solvent; and
- Assuring that consumers are protected in the event that an AHP fails (including administering a federal guarantee fund for AHPs).

Transferring regulatory authority from the states to the federal government would require the creation of a large federal infrastructure to monitor these new federally regulated insurance companies. **In 1997, the Department of Labor testified that it had the resources to review each ERISA plan only once every 300 years**. This level of regulation would not be adequate for federally certified AHPs, which operate more like insurance plans than large

employers. Regulation of AHPs would require DoL to hire new staff and build the capacity to regulate insurance functions, such as solvency, that are already regulated by the states.

*6) **Consumer Confusion:*** Exempting AHPs from state law would create consumer confusion about whether state or federal protections would apply to their coverage. Most consumers are currently accustomed to calling their state insurance commissioner when they have a problem with their small group coverage. **Under AHP legislation, they would likely have to call the Labor Department.** States have passed numerous laws regarding fair marketing practices, rating limits, financial standards and access and quality safeguards. These protections would not apply to consumers enrolled in AHPs that are exempt from state law.

III. Exempting AHPs from State Reforms is not the Solution to the Problem of Access for Small Firms – Many of the Purported Benefits of this Legislation have been Overstated

While we strongly support efforts to expand coverage to small employers, we do not believe that the regulatory approach advocated by AHP proponents – exempting AHPs from state law and placing them into a vacuum of federal regulation – will achieve this goal.

Proponents believe that pending legislation to exempt AHPs from state laws would reduce health insurance costs, thus allowing more small firms to offer coverage. They contend that AHPs could offer lower costs, such as by reducing administrative costs and improving the purchasing

power of small firms. However, the potential for savings under AHP legislation has been overstated:

- ***AHPs will not reduce administrative costs:*** AHPs would function as federally licensed insurance companies, which could not obtain administrative savings comparable to large, single employers that self-fund benefits under ERISA. An analysis by William M. Mercer, Inc., found that this legislation provides no opportunity for AHPs to reduce administrative costs for small businesses. The report states that AHPs would need to assume most of the same administrative costs borne by insurers. Moreover, most associations sponsor health insurance as a revenue-producing membership benefit. They charge licensing fees and royalties and condition eligibility on the payment of membership dues. When these additional charges are added, Mercer found that **AHPs would increase administrative costs** for small firms by 1.5% to 5% of premiums.

- ***AHP's ability to negotiate discounts is not demonstrated:*** Proponents claim that AHPs can reduce costs by aggressively negotiating with insurers for lower rates. However, a 1997 survey of association executives concluded that, "few association executives know what the association is paying to vendors (i.e., insurers, administrators, etc.) with respect to expenses, fees and commissions" (W.F. Morneau & Associates, 1998). Proponents also claim that they could bypass insurers and negotiate better rates directly with health care providers. However, few self-funded health plans contract directly with health care providers. If they did engage in direct contracting, association plans (which collectively represented less than 5% of private insurance premiums in 1997) would be hard pressed to obtain the same discounts with providers as major insurers. As such, AHPs will have little ability to reduce underlying

medical costs (i.e., costs for doctors, hospitals and pharmaceuticals) that account for the recent growth in premiums.

- ***Savings from self-funding may be elusive***: Proponents claim that AHP legislation will allow small businesses to self-fund and avoid benefit mandates, just like some Fortune 500 employers. The reality is that small firms can already self-fund. However, as I mentioned previously, a study by researchers at RAND found that the number of small firms that self-fund benefits has declined by 67% over the past decade (Marquis & Long, 1999). The reason: HMOs – which are typically subject to state regulation -- have proven to be more attractive to small firms. Moreover, the RAND study found that self-funded plans are often more costly than HMOs and offer premiums that are comparable to other fully insured plans.

The one sure way that federally certified AHPs could offer lower costs is by taking advantage of the unlevel playing field. AHPs could offer scaled-down benefits that attract healthier-than-average groups. It is important to recognize that **20% of the population accounts for 80% of health care costs in any given year**. By attracting low-cost populations, AHPs could offer significant price savings, at least initially. The state-regulated insurance market would take a double hit: It would be forced to carry the cost of mandated benefits and its healthier small firms would be cherry-picked by this new category of federally licensed insurers.

AHP legislation is a shell game, rather than a serious proposal for the uninsured. The principal effect of this legislation would be to force small groups to abandon the state-regulated small group insurance market in favor of AHPs. AHPs could offer lower rates initially, but when the cost of coverage rises they could disband and their members would be guaranteed access

back into the insured small group market under HIPAA. Collapse of the state-regulated market could compromise any potential gains in the new federal AHP market.

I am compelled to say a word about a study funded by the National Federation of Independent Business (NFIB) purporting that AHP legislation would provide coverage for as many as 8 million uninsured individuals. This study should be viewed with skepticism, as it fails to even consider the negative effect of this legislation on the existing state-regulated small employer market. Moreover, an analysis by the Barents Group/KPMG found that this study suffers from serious methodological flaws that undermine its credibility and its purported findings. As the Barents/KPMG analysis points out, "...if AHPs are successful in reducing costs by attracting a healthier risk-pool, any increase in coverage could be off-set by reductions in coverage for the rest of the small group market."

IV. Exempting AHPs/MEWAs from State Health Reforms Raises Larger Public Policy Issues

A major challenge to the private health insurance market is the desire for healthy groups to segment themselves from less healthy groups. AHPs are one of a long line of organizations that have sought to avoid the cross subsidies that exist under state reforms.

The problem is that the more groups that are exempted from state law, the more unworkable state health insurance reforms become -- with the inevitable result of more and more uninsured left in the states. In order to make health coverage more accessible and affordable for small groups, state reforms need a large pool that includes both healthy and unhealthy people.

Congress must recognize that the real public policy issue is that exemptions from state law would cause the pool of state-regulated groups to shrink, and state access and affordability reforms to unravel. This would result in a smaller set of groups and individuals left in the state-regulated insurance pool -- likely the most unhealthy and expensive to cover. Once state reforms unraveled, the federal government would be forced to reinvent these carefully constructed reforms – including rate regulation -- at the national level. The federal government would become the primary regulator of health insurance.

V. Congress Should Focus on Tax-Based Solutions For Small Firms And The Uninsured, Such As The Proposal Released By BCBSA

BCBSA believes that improving access to health insurance among small employers should be a priority for policymakers. We are concerned that the combination of health care cost increases and worsening economic conditions could cause the number of uninsured to increase. According to a report by the National Coalition on Health Care, the uninsured could reach 45 million by the end of 2002. The most serious gap in the uninsured exists for very small firms with low-wage workers and families that have no access to employer-based health insurance.

The lower the company's wage structure, the less likely it is to offer insurance. According to a 2000 survey of small businesses by the Blue Cross Blue Shield Association and the Employee Benefit Research Institute (EBRI), companies with a high proportion of low-wage workers were half as likely to offer health benefits as high-wage companies. This survey found that nearly 70 percent of small employers that do not offer benefits cited the cost of coverage as the major

reason. Research indicates that low-wage workers are interested in coverage, but are either not offered coverage or are not able to afford coverage.

In 1999, BCBSA unveiled a two-part program to address the problem of the uninsured that focuses on the unique problems of small employers. First, BCBSA urges Congress to adopt a new litmus test to assure that no legislation is enacted that will increase the number of the uninsured. Approximately 300,000 Americans lose their health insurance coverage for every one percent increase in private health insurance costs, according to estimates by the Barents Group/KPMG and the Lewin Group.

Second, BCBSA recommends that Congress enact targeted solutions that address significant gaps in insurance coverage. Specifically, Congress should enact:

- **Tax Credits For Low-wage Workers in Small Firms.** A disproportionately high share of workers in small firms are uninsured -- two thirds of workers in low wage firms with fewer than 10 employees are uninsured. Tax credits for workers in low-wage firms are needed to make health coverage more affordable for small employers and their low-income employees.

- **Full Tax Deductibility For The Self-Employed.** Those who are self-employed should be allowed to deduct the full cost of their health insurance, just like larger employers can today. Congress has already moved in this direction by approving legislation that will phase in full deductibility for the self-employed. Congress should phase in full-deductibility for the self-employed immediately.

- **Full Tax Deductibility For Individuals Without Employer-Sponsored Coverage.** The current tax system disadvantages individuals who do not have access to employer coverage. These individuals should be allowed to deduct the cost of purchasing their coverage.

- **Subsidies for Displaced Workers:** We hope that Congress can reach agreement on subsidies for workers who have lost their job as a result of the recession. Temporary subsidies are an important way to provide stability and continuity for displaced workers who may otherwise be unable to afford coverage.

- **Federal Grants to States for Targeted Initiatives.** Targeted federal grants could be used to help other segments of the uninsured. These grants could be used to provide funding for private initiatives, community health centers and state high-risk pools.

CONCLUSION

In summary, as you consider federal legislation that exempts groups from state law, we urge you to consider the serious, unintended consequences on a highly complex market. **First and foremost, Congress should recognize that states have laid the foundation for successful reform by creating large pools of small employers that assure meaningful cross subsidies.** If federal legislation is proposed, it should build on state reforms by addressing affordability through the tax system and take care not to unintentionally undermine existing state reforms.

If Congress enacts AHP legislation or any other legislation that destroys state reforms, it will be left with a market that is built upon aggressive risk selection and fragmented insurance pools –

factors that will prevent the effectiveness of federal intervention to help the uninsured. The federal government will need to do exactly what the states have done, but will not have the infrastructure to regulate the market with the same responsiveness to consumer protection.

Thank you for the opportunity to speak to you on this important issue. BCBSA looks forward to working with Congress to address the access and affordability needs of small employers and others in a manner that does not unravel important small group insurance reforms.

Statement of Associated Builders and Contractors

STATEMENT SUBMITTED TO
THE HOUSE COMMITTEE ON SMALL BUSINESS

Hearing on Small Business Access to Health Care

February 6, 2002

Speaking for the Merit Shop

1300 North Seventeenth Street
Rosslyn, Virginia 22209
(703) 812-2000

Associated Builders and Contractors (ABC) appreciates the opportunity to submit the following statement for the official record. We thank Chairman Don Manzullo (R-IL), Ranking Member Nydia Velázquez (D-NY) and members of the Committee for addressing the problems small businesses face in providing quality health insurance for themselves and their employees.

ABC is a national trade association representing over 23,000 contractors, subcontractors, material suppliers, and related firms from across the country and from all specialties in the construction industry with a network of 82 state chapters. Our diverse membership is bound by a shared commitment to the merit shop philosophy of awarding construction contracts to the lowest responsible bidder, regardless of labor affiliation, through open and competitive bidding. With 80 percent of construction today performed by open shop contractors, ABC is proud to be their voice.

The construction industry, which represents 12 percent of the Gross National Product and 9 percent of the Gross Domestic Product, is an industry of small businesses as 94% of all construction companies are privately held and 1.3 million construction companies are not incorporated. As the nation's second largest employer with 6 million workers, the construction industry continues to create new and beneficial jobs each year. For every $1 million spent in construction, $3 million in economic activity is generated and 13 new permanent jobs are created.

To remain at the present level of activity, the construction industry needs an additional quarter of a million (250,000) workers per year to replace an aging and retiring workforce. One of the key elements to attracting and retaining workers and remaining competitive in any industry is to provide high quality, flexible health benefit plans. Maintaining cost effective health insurance plans is a key ingredient in achieving this objective.

The Associated Builders and Contractors - Association Health Plan

Providing quality health care benefits is a top priority for ABC and its members. ABC had operated an Association Health Plan for more than 40 years through the ABC Insurance Trust. Because of overwhelming costs in complying with overlapping, inconsistent and often incompatible state laws, our Association Health Plan carrier was forced to drop their AHP coverage. Today, ABC continues to provide a full array of insurance benefits, but has been forced to work with multiple, regional health insurance providers. ABC now serves as a broker, providing our membership with the most competitive carriers and rates in their area. ABC is a perfect example of how a trade or professional association, serving as a purchasing pool for employers, can have a

significant impact upon the small employer health insurance market in both price and design.

The ABC Insurance Trust was founded in 1957 by five contractors who could not buy group health insurance for their employees in the open market due to their size. Through 1999, the ABC Insurance Trust served as a voluntary purchasing pool for members of the association. An important component of the plan's long-term success was that it was guided by contractor members who serve as trustees. As participants in the program, they acted in the best interest of their fellow members and their employees. Participation of the board of trustees is a key ingredient in aggregating the voice of employers to negotiate price and coverage with insurance carriers and other providers.

ABC's Association Health Plan program offered HMOs, PPOs, and traditional health insurance plans including both in-network and out-of-network benefits. All of ABC's plans provided wellness benefits with coverage for physicals and annual check ups. ABC continues to offer dental coverage, group life insurance, and disability programs to serve members of the association. Today the program covers 44,000 employees and their families nationwide. A majority of those covered work for small construction firms with 10-20 employees.

ABC's Insurance Trust operates in full compliance with the Employee Retirement Income Security Act (ERISA) of 1974 reporting requirements, with the Consolidated Omnibus Reconciliation Act (COBRA) of 1985 and with the Health Insurance Portability and Accountability Act (HIPPA) of 1996. Complying with the federal HIPPA legislation requires ABC and other associations to provide open access to all members and provide credit for prior coverage. In fact, Association Health Plans are specifically referenced and defined in the HIPPA legislation and are required to take all members under HIPPA guidelines.

Similar to large employers, AHPs could provide economies of scale in numerous areas. The ABC plan, which operated nationally, had total expenses of 13 ½ cents (13.5%) for every dollar of premium. These costs included all marketing, administration, insurance company risk, claim payment expenses and state premium taxes. Alternatively, small employers who purchase coverage directly from an insurance company can experience total expenses of 30 cents (30%) for every dollar of premium or more. It stands to reason that small businesses that purchase coverage through an Association Health Plan can expect to save 15 to 20 percent, or more. Another component in the AHP is that any profit margin generated by the health plan in a given year does not go to the stockholders of the insurance company, they stay in the plan and inure to the benefit of participants by keeping costs lower in the future.

Bonafidé trade associations like ABC have an established infrastructure that allows them to communicate with members more effectively because of their pre-established relationship. This allows associations and trade groups to provide employers with unique plan designs. This is a very valuable option for member companies of ABC in that it provides additional benefits over and above what many insurance vendors provide today. ABC has successfully tailored the products and services specifically for the needs of ABC contractor members. For example, all medical plans offered through the ABC Insurance Trust also provides vision coverage, which includes coverage for safety glasses, an item unique to the construction industry.

The Problem

The health benefit programs offered by ABC are consistent with Congress' goal of meeting consumer demands for expanded benefits by providing high quality health benefit options. One of the principle reason's for Congress's enactment of the Employee Retirement Income Security Act of 1974, ERISA, was to foster the growth of employee benefit plans by promoting uniform federal regulation of those plans.

However, despite the great need for increased health coverage and our members ability to deliver it, increasing federal and state regulations have not always had the positive impact that they purport for small employers and actually obstruct the development of innovative and effective health benefit programs.

A number of state reforms, such as those enacted in Maryland have actually forced ABC to increase rates and reduce benefits in order to comply with the law. State health insurance reforms and community rating in New York forced ABC's insurance carrier to completely withdraw from the market for employers with less than 50 employees. When these and other state reforms occur, small employers are left with fewer alternatives for health insurance coverage for themselves and their employees.

Recent mergers of health insurance companies have also reduced competition and alternatives for employers who seek access to quality and affordable health insurance. Today, there is a great need to bring more competition back into the system rather than continually reducing it.

The Solution

ABC strongly supports extending ERISA preemption of costly state mandated benefits, currently available for larger, self-insured plans, to bona fide association health plans and professional societies for small businesses. Without the benefit of ERISA's nationally uniform standards, many of the most creative, innovative and cost-effective

employer-sponsored health benefit plans could not continue to exist because of the overwhelming costs of complying with overlapping, inconsistent and incompatible state laws.

Now more than ever, Congress needs to pass legislation that would extend the time-tested ERISA preemption to bona-fide trade associations. ABC strongly supports H.R. 1774, the Small Business Health Fairness Act of 2001" which was introduced in the U.S. House of Representatives by Representatives Ernie Fletcher (R-KY) and Cal Dooley (D-CA) and S. 858, the Senate companion measure introduced by Senator Tim Hutchinson (R-AR).

Additionally, Chairman Bill Thomas (R-CA), in conjunction with Representatives Fletcher, Dooley and Lipinski (D-IL) were able to pass a bipartisan access amendment during House debate of the Bipartisan Patient Protection Act of 2001(H.R. 2563) which provides for the creation of Association Health Plans. This represents the fourth time the United States House of Representatives has passed an Association Health Plan provision in some form or another.

In conclusion, Association Health Plans provide affordable health coverage to small businesses, and extend coverage to uninsured people. While AHPs are not the entire answer to the problem of the uninsured, AHPs are an essential component of the solution for the uninsured. AHPs are important for many working families employed in small businesses who otherwise could not afford coverage. At a time when certain coverage are rapidly being manipulated into costly, state mandated benefits, employers may be increasingly mandated out of coverage, or worse yet, out of business.

ABC appreciates this opportunity to submit comments on such a vital issue. We look forward to continuing a constructive dialogue on how to increase access to affordable and competitive health insurance for small businesses.

Small Business News

Chairman Don Manzullo (IL-16)
U.S. House Committee on Small Business

FOR IMMEDIATE RELEASE
February 6, 2002

Contact: Rich Carter or Mike Arlinsky
(202) 225-5821

Manzullo: Small Employers Need Congress' Help Battling Surging Health Care Costs

(WASHINGTON) House Small Business Committee Chairman Don Manzullo (R-IL) today urged his colleagues to pass legislation this year that would give America's 25 million small employers better options to battle the surging costs of health care for their employees.

Manzullo kicked off the new congressional session with a hearing Wednesday exploring avenues to bring down health care costs for small business owners and their employees, who make up 60 percent of the 43 million uninsured Americans. Witnesses at the hearing, including U.S. Rep. Ernie Fletcher (R-KY), called for legislation creating Association Health Plans, Medical Savings Accounts and the immediate 100 percent deductibility of health care costs for the self-employed.

Association Health Plans would bring down health care costs by allowing small employers to band together and purchase group health insurance at the same economies of scale benefitting large corporations. Up to 8.5 million uninsured small business workers could receive health care coverage because of the cost savings of AHPs, Fletcher said. Manzullo is a strong support of Fletcher's legislation, the Small Business Health Fairness Act (H.R. 1774), which calls for national AHPs.

The committee also discussed the benefits of expanding Medical Savings Accounts, which allow employers to contribute money to accounts set up for their employees to purchase their own health care. MSAs were created by Congress in 1996 but have not realized their full potential because of limits on participants and limits on contributions.

In addition, the committee discussed legislation sponsored by Chairman Manzullo and Ranking Member Nydia Velazquez that would allow the self-employed to immediately deduct 100 percent of their health care expenses from their income taxes. Currently, corporations can deduct 100 percent of their employees' health care costs while the self-employed can only deduct 70 percent of the expenses.

"The surging costs of health care continue to pummel our small employers. Of the 43 million uninsured Americans, 60 percent work for small businesses which can't afford to purchase health care coverage for them," Manzullo said. "Our small employers need options — like Association Health Plans, Medical Savings Accounts and full tax deductibility — to battle these skyrocketing expenses. Without our help, there will surely be many more uninsured Americans living without the security of health insurance."

(END)

February 22, 2002

The Honorable Donald Manzullo
Chairman
Committee on Small Business
U.S. House of Representatives
2361 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Manzullo:

On behalf of the 600,000 members of the National Federation of Independent Business (NFIB), I was deeply troubled by the Blue Cross/Blue Shield (BCBS) testimony given by Ms. Mary Nell Lehnhard at the "Small Business Access to Health Care" hearing on February 6, 2002. Thank you for the opportunity to set the record straight on Association Health Plans (AHPs).

The problem of uninsured individuals in our country is largely a problem of small business owners and their employees. Of the 43 million uninsured Americans that exist today, over 60 percent are either self-employed or working in a firm with fewer than 100 employees. The high rate of uninsured in the small business community is due to the lack of available options for small business and an increasingly shrinking small group insurance marketplace.

In addition, small businesses that currently offer health benefits have been experiencing double digit premium increases, with some NFIB members seeing increases of 40 percent or higher. It's predictable that a big insurance monopoly wants to maintain the status quo - after all, that's how monopolies protect their competitive advantage - however, it is simply not acceptable when the status quo means even more small business owners go without needed health coverage for their families and employees. AHPs will help break the status quo by introducing competition into the marketplace and giving small business a real choice for affordable health care.

There are several questions I'd like to raise about the testimony of BCBS. First, Ms. Lehnhard sighted the Congressional Budget Office (CBO) study of 2000 several times in her written and oral testimony. In February 2000 before this Committee, CBO admitted that it based its findings solely on a study done by Steve Long and Susan Marquis. The problem with the Long and Marquis study, however, is that it was not specific to employer sponsored AHPs, but evaluated together all types of group purchasing arrangements that small employers may participate in, including those established by state governments. How does Blue Cross/Blue Shield testify to the validity of the CBO study two years after CBO admitted on record that their analysis was flawed? Is BCBS now testifying on behalf of CBO?

In addition to the CBO testimony, BCBS positioned themselves as one of the only players left in the small group insurance market. As you know, Mr. Chairman, small businesses have very few insurance options left in the small group market. What is Blue Cross/Blue Shield's market share in each state? If BCBS is truly not afraid of competition, as they claim, why are they unwilling to release data about the share of the market they have in each state? In fact, the reality is that insurance companies would

largely underwrite many AHP policies, meaning more business for insurance companies. Isn't Blue Cross/Blue Shield's real concern that they will have to offer a more competitive rate to small businesses?

AHPs could help reduce the number of uninsured and ease the burden on small business by giving them the same accessibility, affordability, and choice in the health care marketplace that big business now enjoys. When BCBS testified that several states currently provide a large group pooling apparatus for small business, they missed the point entirely. One large group is not enough to bring competition. Only through competing, sizable groups of insured populations will small business be able to shop among several options for the most affordable coverage. It seems that this competitive environment is what BCBS fears most, and also, why it is so important in order to secure affordable health insurance for small business.

Blue Cross/Blue Shield highlights their concern of "cherry picking" or adverse selection if AHPs are enacted. In fact, it is illegal for AHPs to "cherry pick." Under current HIPAA law (Health Insurance Portability and Accountability Act of 1996) it is illegal to deny coverage based on the health status or claims experience of an individual. AHPs are subject to all the preexisting condition, portability, nondiscrimination, special enrollment and renewability provisions under HIPAA. Does Blue Cross/Blue Shield sell insurance to anyone who asks? If not, isn't that "cherry picking?" It seems ironic that BCBS is concerned about "cherry picking" when every single day small businesses are "cherry picked" by the Blues.

Lastly, Blue Cross Blue Shield claims that the proposed solvency standards for self-funded AHPs remain inadequate and that consumers will be victimized. Representative Fletcher's legislation, H.R. 1774, the "Small Business Health Fairness Act," includes strong solvency requirements and increased state enforcement provisions. To prevent fraudulent plans from forming, the bill requires the plans put up and maintain capital surpluses before they can be certified. In addition, plans must maintain sufficient claims reserves, stop loss insurance and indemnification insurance to guarantee that claims will be paid even in the event of financial difficulty or plan termination. The bill also gives clear and strong regulatory authority to ensure that the Department of Labor in partnership with state regulators are able to ensure that AHPs will meet the very strong certification requirements provided in the legislation. The fact is that small business has moved miles to accommodate every possible concern raised by BCBS. At a certain point, it becomes clear that BCBS has no interest in working toward a solution on AHPs, but rather in preserving the status quo-which is a rate of uninsured that is simply unacceptable for small business. We need to level the playing field and give small business owners the same opportunities as labor unions and large companies - give them greater access and choice to affordable health care in the marketplace by making H.R. 1774 law.

Again, I appreciate the opportunity to set the record straight on AHPs and thank you for your tireless commitment to getting to the truth on this important issue.

Sincerely,

Dan Danner
Vice President
Federal Public Policy

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